TEXAS SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

INTERIM REPORT TO THE 81ST LEGISLATURE

December 2008

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THE SENATE OF TEXAS
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December 17, 2008

The Honorable David Dewhurst
Lieutenant Governor of Texas
P.O. Box 12068
Austin, Texas 78711

Dear Governor Dewhurst:

The Senate Committee on Health and Human Services submits this report in response to the interim charges you have assigned to this Committee. The Committee held eight public hearings to consider invited and public testimony from affected consumers, health and human service providers, and agency personnel regarding all of its charges. This report includes a review of issues and makes recommendations related to developmental disabilities, Medicaid outcome-based systems, resiliency and disease management, CPS caseworkers, foster care, child abuse prevention, wellness issues, nursing homes, pandemic flu, health enterprise zones, adult stem cells, and the health care workforce. Please note that the joint Medicaid reimbursement study with the Senate Committee on Finance will follow in a separate report.

The Committee has carefully considered all of the testimony received on its charges in order to provide you with these recommendations. We appreciate the leadership and foresight you have displayed in asking this Committee to monitor and seek remedies to these key issues, and we trust that the recommendations offered in this report will serve to improve health care and human services in Texas.

Respectfully submitted,

Senator Jane Nelson
Chair

Senator Bob Deuell
Vice-Chair

Senator Robert Nichols

Senator Dan Patrick

Senator Eliot Shapleigh

Senator Carlos Uresti

Senator Royce West

Senator Judith Zaffirini

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TABLE OF CONTENTS

Charge # 1 Intellectual and Developmental Disabilities

Monitor the Department of Aging and Disability Services' improvement plan for the system of care for individuals with developmental disabilities, focusing on efforts to improve state schools and provide more community care options. Evaluate the process for preventing, reporting, and investigating abuse and neglect in state schools, ICFs/MR and the Home and Community-Based Services (HCS) program. Determine the short-term and long-term financial impact of increasing the number of individuals served in home or community locations and the financial impact this shift has on state schools. Monitor the department's efforts to convert institutions to community care providers through the money-follows-the-person program designed to improve access to community care services. Specifically make recommendations on:

- *how to further improve the system of care for individuals with developmental disabilities;*
- *preventing, reporting, and investigating abuse and neglect;*
- *developing a transition plan for reducing waiting list for community care service;*
- *incentives for converting institutions into community care providers; and*
- *a long term plan to address issues that result from the current federal Department of Justice investigation*

Background

This report focuses on Texas' support services for persons with intellectual and developmental disabilities and the need for quality services, regardless of the setting in which they receive care. The Department of Aging and Disability Services (DADS) has made great strides in improving

its regulation and authority over these programs. However, this report recommends additional improvement measures.

Persons diagnosed with intellectual/developmental disabilities (mental retardation) are eligible for Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) services from the state if they are in need of, and able to benefit from, the active treatment provided in the 24-hour supervised residential setting of an ICF/MR and are eligible for Supplemental Security Income (SSI) or are deemed financially eligible for Medicaid. These Medicaid long term care services are separated into entitlement services and waiver services.

Medicaid-eligible individuals with intellectual/developmental disabilities are entitled to receive care in certain institutional settings, including state schools and community ICFs/MR. The facilities range in occupancy from 4 persons to a much larger population. These facilities provide 24-hour support services for individuals needing assistance with their daily lives. Services include nursing care; habilitation; nursing and prescription services; skills training; speech, occupational and physical therapy; and adaptive aids, such as a cane, wheelchair, or appliance to assist in eating when holding a utensil is difficult.[1]

Medicaid Section 1915(c) waiver services are an alternative to the ICF/MR institutional setting. These programs provide services to individuals in a community setting. When providing these services, states may limit eligibility, the geographical location in which services are provided, the

[1] Department of Aging and Disability Services, *Testimony before the House Select Committee on Services for Individuals Eligible for Intermediate Care Facility Services*, p1, February 12, 2008.

scope and amount of services, and the number of people served.[2] Texas' 1915(c) waivers include the Home and Community-based Services waiver (HCS), Community Living Assistance and Support Services waiver (CLASS), Deaf-Blind/Multiple Disabilities Program (DBMD), Texas Home Living (TxHmL) and the Consolidated Waiver Program (CWP).

State policies and procedures for persons with disabilities are subject to both federal statutes and case law. The Americans with Disabilities Act of 1990 (ADA) prohibits discrimination on the basis of disability in employment, state and local government, public accommodations, commercial facilities, transportation, and telecommunications.[3] In order to investigate and correct widespread deficiencies that seriously jeopardize the health and safety of residents of institutions,[4] the Civil Rights of Institutionalized Persons Act of 1980 authorizes the U.S. Attorney General and the Department of Justice to investigate conditions of confinement at state and local government institutions such as prisons, jails, pretrial detention centers, juvenile correctional facilities, publicly operated nursing homes, and institutions for people with psychiatric or developmental disabilities. In June 1999, the US Supreme Court ruled in *Olmstead vs. L.C.* that unnecessary institutionalization violates the ADA. States must provide community-based services for persons with disabilities who would otherwise be entitled to institutional services when:

- The state's treatment professionals determine that such placement is appropriate;
- Affected persons do not oppose such treatment; and

[2] Department of Aging and Disability Services, *Testimony before the House Select Committee on Services for Individuals Eligible for Intermediate Care Facility Services*, p1, (Austin, TX , February 12, 2008).
[3] Department of Justice, A Guide to Disability Rights Laws, (September 2005). Available: http://www.ada.gov/cguide.htm#anchor62335, Accessed: July 24, 2008.
[4] Department of Justice, A Guide to Disability Rights Laws, (September 2005). Available: http://www.ada.gov/cguide.htm#anchor62335, Accessed: July 24, 2008.

- Placement can be reasonably accommodated, after considering the resources available to the state and the needs of others receiving state supported disability services.[5]

State Auditor Report

In July 2008, the State Auditor's Office released an audit report on State Mental Retardation Facilities, DADS and the Department of Family and Protective Services (DFPS). The audit report's objectives include: (1) determining whether DADS ensures that consumers at state schools are aware of their community living options; (2) determining whether DADS has controls in place to ensure that improper care is reported, investigated, and resolved in a manner that promotes safety of consumers; and (3) analyzing the cost to deliver services in community and state-run ICFs/MR.[6] This audit report clearly outlined needed improvements. Both DADS and DFPS stated that they are making necessary policy changes, some of which were enacted before the audit report was released. The report includes the following recommendations:

- DADS should improve documentation of (1) discussions with consumers about their community living options and (2) the reasons supporting DADS' decisions about consumers' living arrangements. Auditors reviewed 157 case files. Of those, 80% did not contain all required sections such as documentation of consumer awareness of community living options. In cases where DADS did not provide consumers with their preferred living arrangements, 12% did not have documented reasons for the community living options not being provided.

[5] Department of Aging and Disability Services, *Testimony before the House Select Committee on Services for Individuals Eligible for Intermediate Care Facility Services*, p25, (Austin, TX, February 12, 2008).
[6] State Auditor's Office, *Audit Report on State MR Facilities, DADS, and DFPS*, p. 1, (July 2008).

- DADS should adopt policies and procedures to address how consumers or guardians are informed of their right to appeal DADS' decisions denying consumer preferences for community living options.
- DADS' central office should better monitor state school employees' decisions regarding consumers' living arrangements by expanding the number of state school files reviewed and discontinuing reliance on state schools to choose the sample of files.
- DADS should periodically review the nurse's aide registry and the employee misconduct registry to ensure that state school employees are not on these lists. Auditors found 10 persons working in state schools who were on one of the lists. DADS immediately terminated these employees upon discovering this information.
- DFPS should strengthen its process for investigating allegations of abuse, neglect, and exploitation at state schools and government-run community facilities. Improvements should include: better record keeping of face-to-face interviews and facility notifications, timely and complete investigations, clarification of requirements for face-to-face contacts, and an increase in the number of quality reviews.
- The audit report also concluded that the cost of care in state schools is significantly higher than cost of care in community ICFs/MR ($335.63 in state schools versus $195.17 in community ICFs/MR). Higher costs at state schools are attributed to direct care staffing, administration, and comprehensive medical care.

DADS Quality Assurance

DADS has a number of quality assurance initiatives within its mental retardation service delivery system. In order to deliver quality services, DADS utilizes a combination of onsite reviews, technical assistance, consumer feedback, and data analysis.

DADS System-Wide

In March 2005, DADS implemented annual onsite Quality Assurance Reviews of all mental retardation authorities (MRAs). These reviews focus on the Person Directed Planning Process and MRA compliance with DADS performance contracts. During a review, DADS' staff interview consumers and family members about their satisfaction with services, service outcomes, and service delivery requirements. DADS provides data from the reviews to the MRAs, allowing overall system and targeted improvement by the MRAs.[7]

The Quality Consulting Program (QCP) provides technical assistance for facilities throughout the state, including state schools and other ICFs/MR and assisted living facilities, to increase positive consumer outcomes and promote evidence based practices. QCP staff, comprised of clinical social workers, nurses, and psychology specialists, conduct onsite visits to collect information, review data, and assist with the standardization of policies and procedures.[8]

DADS utilizes the annual Long Term Services and Supports Quality Reviews (LTSSQR) to survey individuals receiving services through DADS' institutional or home and community-based programs. The reviews include face-to-face surveys of adults participating in ICF/MR or

[7] Department of Aging and Disability Services, *Follow-up packet to the House Select Committee on Services for Individuals Eligible for Intermediate Care Facility Services,*(February 12, 2008), Attachment 5, pg. 1.
[8] *Ibid,* pg. 1-2.

community-based programs and mail surveys of families with children under 18 who receive HCS, TxHmL, CLASS, CWP, and MDCP services. The survey results are analyzed and published annually on the DADS website.[9]

In 2004, DADS joined the National Core Indicators Project (NCI). This national collaborative is comprised of the Human Services Research Institute (HSRI) and member state agencies of the National Association of State Directors of Developmental Disability Services (NASDDDS). NCI aims to develop a systemic process to measure performance and outcomes. The NCI Consumer Survey, completed by consumers in institutional and community-based settings, focuses on obtaining the consumer's perspective on services and supports. Survey data enables DADS to evaluate its services and support programs and compare the results with other states.[10]

DADS' Quality Reporting System (QRS) is a web-based source of information about providers of long-term care services. QRS includes information on nursing facilities, ICFs/ MR, assisted living facilities, adult day care providers, home health and hospice agencies, and home and community-based waiver providers. Table 1 summarizes each type of facility included in the QRS system and the facility information available.

[9] Department of Aging and Disability Services, *Follow-up packet to the House Select Committee on Services for Individuals Eligible for Intermediate Care Facility Services*, (February 12, 2008), Attachment 5, pg. 2.
[10] *Ibid,* pg. 3.

Table 1: QRS Reported Data[11] ***Waiver program info still in progress***

	Locator Information (address, phone, etc.)	Ownership Information	Services Offered	Complaint History: investigated vs. substantiated	Investigation Violations	Inspection Violations	Client Outcome Indicators	Compliance History and Significant Events (change of owner, etc.)	Overall Score (0-100)
Nursing Facilities (freestanding accepting Medicaid/ Medicare and hospital-based)	☑	☑	☑[12]	☑	☑	☑	☑[13]	☑	☑
Nursing Facilities (freestanding not accepting Medicaid/Medicare)	☑	☑		☑	☑	☑			
ICFs/MR and SMRF (State Schools)	☑	☑		☑	☑	☑		☑	☑
Assisted Living Facilities (types A, B, C, and E)	☑	☑		☑	☑	☑			
Adult Day Care	☑	☑		☑	☑	☑			
Home Health and Hospice (Medicare and non-Medicare)	☑	☑	☑	☑	☑	☑			
Home and Community-Based Programs (CBA, CLASS, CWP, DBMD, MDCP, and HCS Providers)	☑	☑	☑		☑ not available for HCS	☑ inspection data availability varies within TxHmL providers		available for some HCS providers	

[11] Developed using information available at DADS, *Long Term Care Quality Reporting System,* Available at: http://facilityquality.dads.state.tx.us/ltcqrs_public/nq1/jsp2/qrsHome1en.jsp?MODE=P&LANGCD=en, Accessed July 24, 2008.
[12] Special services listed.
[13] Available at medicare.gov

QRS provides ratings for Medicaid-certified nursing facilities, hospital-based nursing facilities, state schools and other ICFs/MR. Because scoring methodologies for facility categories vary, DADS cautions against comparisons across types of facilities.[14] In all ratings, QRS utilizes results from DADS Inspections and Investigations as a measure of facility compliance with state and federal regulations. In rating state schools and other ICFs/MR, QRS gives each facility an inspection rating and an investigation rating and adds the two together to generate an overall score.

Although QRS uses the same methodology for state schools and all other ICFs/MR, it categorizes them as distinct providers and does not recommend comparing the two. In rating Medicaid-certified and hospital-based nursing facilities, QRS also incorporates two measures of quality care, the Potential Advantages Score (PAS) and the Potential Disadvantages Score (PDS), indicators of how common problem conditions (e.g., dehydration, pressure sores) are present in the facility compared to all other facilities.[15] QRS does not provide ratings for freestanding nursing facilities that do not accept Medicaid or Medicare, adult day care centers, assisted living facilities, home health care providers, and home and community based waiver program providers.

QRS uses data from DADS' Compliance, Assessment, Registration, and Enforcement System (CARES) regarding regulatory inspections and investigations of complaints performed by DADS. This differs from data available in the IMPACT system DFPS uses to house information about investigations of alleged abuse, neglect, and exploitation. It is

[14] Department of Aging and Disability Services, *How QRS Evaluates All Long Term Care Services,* Last update: (July 10, 2008). Available: http://facilityquality.dads.state.tx.us, Accessed: July 24, 2008.
[15] *Ibid*.

important to note that the information available in QRS regarding investigations is not specific to investigations following allegations of abuse, neglect, and exploitation, but a record of all regulatory compliance investigations DADS performed following the receipt of complaints or notice of incidents.

State Schools

Each year, DADS evaluates its state schools through the Quality Enhancement Review Process. Over a four-day period, a review team comprised of a physician, registered nurse, occupational/physical therapist, consumer rights coordinator, incident management coordinator, active treatment specialist, and generalist observe and conduct record reviews, consumer interviews, and family satisfaction interviews. After this review is complete, each state school receives a report indicating strengths and areas in need of improvement. Each facility, in conjunction with the DADS state office, develops an improvement plan.[16]

The Program Improvement Unit, created in April 2007, develops recommendations and monitors the implementation of programs and activities at state schools, ensuring that residents receive quality services. The unit will also track DADS' compliance with the settlement agreement reached with the Department of Justice regarding Lubbock State School.[17]

[16] Department of Aging and Disability Services, *Follow-up packet to the House Select Committee on Services for Individuals Eligible for Intermediate Care Facility Services,* (February 12, 2008), Attachment 5, *p. 4.*
[17] *Ibid*. pg. 3.

Waiver Programs

In 2003, the Centers for Medicare and Medicaid Services (CMS) added an additional requirement to the Medicaid Section 1915(c) new/renewal waiver application process, requiring states to demonstrate their capability to implement the requested waiver program in accordance with federal law and provide a detailed explanation of the state's Medicaid Waiver Quality Management Strategy.[18] Specifically, a state's quality management strategy must include: how the state will determine compliance with waiver requirements; a description of the responsibilities of involved parties in the quality management process; a description of the processes involved in the discovery, remediation, and improvement phases; information on how the state collects its quality management data and how often this data is communicated to other involved parties; and periodic evaluation and revision of the Quality Management Strategy.[19]

The Quality Assurance and Improvement (QAI) Data Mart, funded by the 2003 Quality Assurance/Quality Improvement Real Choice Systems Change grant, is a tool used for data reporting and analysis.[20] The QAI Data Mart enables DADS to generate standardized reports and create custom queries of provider performance and consumer outcomes.[21] Specifically, the QAI Data Mart consists of measures (quantifiable data) and dimensions (filters). The combinations of measures and dimensions enables DADS to

[18] National Association of State Directors of Developmental Disabilities, *State HCBS Waiver Quality Management Strategies,* Available: http://www.nasddds.org/StateHCBSWaiverQualityManagementStrategies.shtml, Accessed: July 24, 2008.
[19] *Ibid*.
[20] Department of Aging and Disability Services, *Section I, Part B Demonstration Implementation Policies and Procedures,* Available: http://www.dads.state.tx.us/providers/pi/mfp_demonstration, Accessed: July 24, 2008.
[21] Department of Aging and Disability Services, *Section I, Part B Demonstration Implementation Policies and Procedures,* Available: http://www.dads.state.tx.us/providers/pi/mfp_demonstration, Accessed: July 24, 2008.

produce customized reports.[22] The QAI Data Mart also helps DADS meet CMS' requirement that DADS produce evidence for quality management measures for 1915(c) waiver programs.[23]

DADS Improvement Plan

The U.S. Department of Justice's June 2005 visit to the Lubbock State School sparked concerns about the quality of state school facilities in Texas. Later, the Department of Justice expanded its investigation to include all state schools. In her February 12, 2008 testimony to the House Select Committee on Services for Individuals Eligible for Intermediate Care Facility Services, DADS Commissioner Adelaide Horn noted DADS' recent improvements to state school staffing, standardization of procedures, and waiver services.[24]

State School Improvements

DADS' fiscal year (FY) 2008-2009 appropriation is $1.04 billion, a $121 million increase from FY 2006-2007's adjusted base budget. The additional appropriated funding will enable DADS to hire 1,690 additional full time employees (FTEs) over the biennium and increase staffing to the national state school ratios.[25] Of these additional positions, 1,211 FTEs would be medical and direct care employees (e.g., registered nurses, licensed

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[22] Center for Health Transformation, *Best Practices in Medicaid - Texas, Available:* http://www.healthtransformation.net/cs/texas/_best_practices_in_medicaid_texas, Accessed July 24, 2008.
[23] Department of Aging and Disability Services, *Follow-up to the House Select Committee on Services for Individuals Eligible for Intermediate Care Facility Services,*(February 12, 2008), Attachment 5, pg. 2-3.
[24] Department of Aging and Disability Services, *Testimony before the House Select Committee on Services for Individuals Eligible for Intermediate Care Facility Services*, (Austin, TX, February 12, 2008).
[25] Department of Aging and Disability Services, *Follow-up to the House Select Committee on Services for Individuals Eligible for Intermediate Care Facility Services,* (February 12, 2008), Attachment: State Mental Retardation Facilities Hiring Project FY 2008.

vocational nurses, occupational/physical therapists, psychologists, MHMR service aides). Four hundred seventy-nine of the additional employees would work as operational support staff (e.g., food and laundry personnel, receptionists, maintenance staff). As of February 2008, DADS staffed 677 of the positions. DADS has also staffed eight new superintendents since October 2005, and added two new program liaisons and a Program Improvement Unit at the DADS State Office.[26] DADS has improved its hiring process by completing required job audits for additional medical professional positions; raising the salaries for newly hired and incumbent registered nurses, licensed vocational nurses, and registered therapists; and developing applicant recruitment plans for each state school facility.[27] However, DADS continues to struggle to retain staff. In FY 2007, Texas state schools had an average direct-care staff turnover rate of 46 percent.[28]

DADS has also standardized many of its state schools' operations in order to establish consistency across all of its state schools, including:

- Person-Directed Planning System: standardized process for consumer-directed Personal Support Plan (PSP);
- Values-Based Culture Training: all state schools have received training and the curriculum, which includes treating individuals with respect and allowing them to make their own choices, is now a part of the new hire orientation;
- Unusual Incident Trend Analysis System: allows identification of state school system trends and patterns;

[26] Department of Aging and Disability Services, *Testimony before the House Select Committee on Services for Individuals Eligible for Intermediate Care Facility Services*, (February. 12, 2008).
[27] Department of Aging and Disability Services, *Follow-up to the House Select Committee on Services for Individuals Eligible for Intermediate Care Facility Services,* (February 12, 2008), Attachment: State Mental Retardation Facilities Hiring Project FY 2008.
[28] State Auditor's Office, *An Audit Report on State Mental Retardation Facilities, the Department of Aging and Disability Services, and the Department of Family and Protective Services*. p 42. (June 2008).

- Assessment Tools for Side Effects of Medication: all state schools have received training on two standardized assessment scales; and
- Standardized Rights Assessments: standardized assessment has been developed and is currently in use by all state schools. [29]

Other DADS projects include improving the Comprehensive Quality Enhancement Reviews in order to ensure consistent evaluation of services in state schools statewide; reducing the use of restraints and restrictive practices and measuring these reductions; and revising the Prevention and Management of Aggressive Behavior curriculum and conducting related training. DADS staff statewide has also received competency training by the Columbus Organization which covers the identification and reporting of abuse, neglect, and exploitation; client rights; and nursing practices. DADS staff are completing follow up reviews in order to assess staff understanding of training topics after completion of the competency training.[30]

Waiver Improvements

Through expansion of the Consumer Directed Services (CDS) Option and key legislation from last session, DADS is planning to implement several improvements within its 1915(c) Medicaid waiver programs. CDS enables consumers to hire, train, supervise, and terminate their service providers and set provider wages and benefits. The CDS option began in 2001 in some of the CLASS services and is currently included in selected DBMD and HCS services and all of the TxHmL services. DADS plans to expand the CDS option to selected CWP services within the next year. Rider 45 from last session

[29] Department of Aging and Disability Services, *Follow-up to the House Select Committee on Services for Individuals Eligible for Intermediate Care Facility Services,* (February 12, 2008), Attachment: Best Practice Initiatives for State Mental Retardation Facilities (State Schools).
[30] *Ibid:* Attachment: Best Practice Initiatives for State Mental Retardation Facilities (State Schools).

increased the cost limits of the CBA, CWP, CLASS, DBMD, and HCS 1915(c) Medicaid waiver programs to 200 percent of institutional costs, and the cost limit of the MDCP waiver program to 50 percent of institutional services. Rider 45 also authorized DADS to use General Revenue to fund costs exceeding the waiver limit for individuals who cannot be served safely in an institutional setting and whose needs exceed the waiver cost limits. In preparation for its FY 2010-2011 Legislative Appropriations Request, DADS discussed the prospect of expanding its waiver programs with stakeholders and identified potential barriers to expansion including the availability of direct care staff and specialized service providers and the ability to provide a sufficient rate structure for providers participating in the waiver programs.[31]

In FY 2006, the Texas Health and Human Services Commission (HHSC) received a grant from the CMS National Direct Service Workforce Resource Center. The grant provided technical assistance through the Resource Center to identify barriers and possible solutions to decrease the high turnover rates of DSW in Texas. HHSC delegated the task of completing this Texas DSW Initiative to DADS. In June 2008, DADS released its *Stakeholder Recommendations to Improve Recruitment, Retention, and the Perceived Status of Paraprofessional Direct Service Workers in Texas*, which provides 14 recommendations using stakeholder input gathered at a number of focus groups held around the state.

[31] Department of Aging and Disability Services, *Testimony before the House Select Committee on Services for Individuals Eligible for Intermediate Care Facility Services*, (Austin, TX, February. 12, 2008).

Reporting Abuse and Neglect

DADS and DFPS play key, but differing, roles in handling allegations of abuse and neglect of the developmentally disabled. DADS has a more regulatory role, evaluating facility compliance with state and federal requirements, while DFPS handles a considerable amount of the investigation process regarding allegations of abuse, neglect, and exploitation involving individuals with developmental disabilities.

Department of Family and Protective Services

The Statewide Intake (SWI), operated by DFPS, serves as a centralized reporting system for allegations of abuse, neglect, and exploitation (ANE) of vulnerable persons. It allows individuals to make reports by phone, internet, fax, and traditional mail correspondence 24 hours a day, 7 days a week.[32] It is SWI's responsibility to assess information from the reporter to determine whether the allegation meets the statutory definition of ANE. In FY 2007, the Statewide Intake received a total of 647,909 calls (telephone, mail, fax, internet), a 21.2 percent decrease from 2006.[33] Of the total reports, about half (335,500) were reports of alleged ANE, while the other half were special requests, requests for information, or unrelated and required a referral.

[32] Department of Aging and Disability Services, *SWI Statewide Intake Overview,* Available: http://www.dfps.state.tx.us/Documents/about/Data_Books_and_Annual_Reports/2007/databook/SWI_FY07.pdf, pg 1, Accessed: July 24, 2008.
[33] Department of Aging and Disability Services, *SWI Statewide Intake Overview,* Available at: http://www.dfps.state.tx.us/Documents/about/Data_Books_and_Annual_Reports/2007/databook/SWI_FY07.pdf, pg 3, Accessed: July 24, 2008.

DFPS investigates allegations of abuse, neglect, and exploitation of children, the elderly, and persons with disabilities.[34] The DFPS Adult Protective Services (APS) division has two program areas that serve individuals with disabilities depending on the setting: APS In-Home Investigations and Services and APS MH and MR Investigations. APS In-Home Investigations and Services conducts in-home investigations of allegations related to ANE of adults 65 years and older or adults age 18-64 with a disabling condition. In FY 2007, APS conducted 64,459 in-home investigations, with 45,934 of these confirmed. Of the 37,322 confirmed victims of in-home ANE in FY 2007, 17,398 (46.6 percent) had a disabling condition.[35]

The Adult Protective Services MH and MR Investigations Program investigates allegations involving adults and children with developmental disabilities occurring in state operated or contracted settings including state schools, state hospitals, state centers, state or community operated ICF/MR facilities, community MHMR centers, and facility and community center contractors (including HCS and TxHmL Waivers).[36] However, DFPS does not investigate ANE allegations occurring in private ICFs/MR. If DFPS receives a report involving ANE at a privately operated ICFs/MR, DFPS will refer the

[34] Department of Family and Protective Services, *About DFPS,* Available: http://www.dfps.state.tx.us/About/, Accessed July 24, 2008.
[35] Department of Family and Protective Services, *Adult Protective Services In-Home Overview,* http://www.dfps.state.tx.us/Documents/about/Data_Books_and_Annual_Reports/2007/databook/APS_FY07.pdf, Accessed July 24, 2008.
[36] Department of Family and Protective Services, *Facility Investigations,* Available: http://www.dfps.state.tx.us/Adult_Protection/About_Adult_Protective_Services/facility_investigations.asp, Accessed July 24, 2008.

report to DADS as it is DADS' responsibility to ensure that the provider completes an investigation of the allegation according to federal regulations.[37]

Within one hour of receiving a report from the statewide intake, the APS MH and MR Investigations Program must notify the administrator of the facility at which the incident occurred. If the allegation involves a child or the serious physical injury, sexual abuse, or death of an adult, APS MH and MR must also notify law enforcement within one hour of intake.[38] The investigative process may include conducting face-to-face interviews with the alleged victim, the alleged offender, and witnesses; collection of evidence such as photographs of the injuries and scene of incident; and review of client records, incident reports, and timesheets.[39] The required timeframe for investigation varies depending on the priority assigned to the allegation. Client contact must occur within 24 hours for priority 1 investigations, within 3 days for priority 2 investigations, and within 7 days for priority 3 investigations. APS has 14 days to conclude Priority 1 and 2 investigations and 21 days to conclude priority 3 investigations.[40]

After completing an investigation, APS prepares a report indicating one of four findings: confirmed (preponderance of evidence indicates that an incident occurred), unconfirmed (preponderance of evidence indicates that an incident did not occur), inconclusive (no

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[37] Department of Aging and Disability Services, *Follow-up to the House Select Committee on Services for Individuals Eligible for Intermediate Care Facility Services,* (February 12, 2008), Attachment: Intermediate Care Facilities for Persons with Mental Retardation, November 2007.
[38] Department of Family and Protective Services, *Adult Protective Services In Home Overview,* http://www.dfps.state.tx.us/Documents/about/Data_Books_and_Annual_Reports/2006/databook/APS_FY06.pdf, Accessed July 24, 2008.
[39] Department of Aging and Disability Services, *Testimony before the House Select Committee on Services for Individuals Eligible for Intermediate Care Facility Services*,, (Austin, TX, February 12, 2008).
[40] Department of Family and Protective Services APS, *Testimony before the House Select Committee on Services for Individuals Eligible for Intermediate Care Facility Services,* p. 10, February 12, 2008.

preponderance of evidence supporting or refuting an allegation), or unfounded (allegation is spurious or patently without factual basis). APS releases the report to the provider, the DADS State Office if a state school or waiver provider is involved, and law enforcement in confirmed cases that could constitute a criminal offense. APS classifies incidents (prior to disposition) that do not meet the statutory definition of abuse or neglect as "Other" and refers these back to the facility.[41] APS does not investigate allegations of violations of clients' rights, property theft, failure to carry out a treatment plan without a resulting incident, failure to maintain adequate staffing levels without a resulting incident, failure to provide care without resulting emotional or physical harm, and incidents involving only the clinical practice of medical professionals.[42]

Of the 8,088 total completed MH and MR investigations conducted by APS, 891 were confirmed. The most common type of facility investigation in FY 2007 occurred in state schools, with 3,470 completed investigations (42.9 percent) and 333 of these confirmed. HCS Programs (including TxHmL data) had the third highest with 1,666 completed investigations (20.6 percent), of which 278 were confirmed. Five hundred ninety-five investigations (7.4 percent) were inconclusive and 324 investigations (4.0 percent) were unfounded.[43]

[41] Department of Family and Protective Services, *Follow-up to the House Select Committee on Services for Individuals Eligible for Intermediate Care Facility Services,* (February 12, 2008), Attachment: Memorandum, p 1-2.
[42] *Ibid*, p 2.
[43] Department of Family and Protective Services, *Follow-up to the House Select Committee on Services for Individuals Eligible for Intermediate Care Facility Services*, (February 12, 2008), Attachment: Total Investigations in MH and MR Settings.

Department of Aging and Disability Services

Different program providers vary in licensure requirements, but remain consistent in regard to DADS oversight. Public and private ICFs/MR require federal certification through CMS, with private ICFs/MR requiring additional state licensure through the DADS Regulatory Services Division. The HCS and TxHmL waiver programs require federal certification but no state licensure, while the CLASS and DBMD waiver programs require state licensure but no federal certification. DADS Regulatory Services Division surveys ICFs/MR, HCS, TxHmL, and DBMD Assisted Living Facility providers annually; CLASS and DBMD Home and Community Support Services Agencies within one year of initial license, again within the next 18 months, and then every three years after that. DADS Provider Services monitors CLASS and DBMD provider contracts annually for compliance.[44] Complaints in any of these provider types will trigger a DADS investigation.

In the event of allegations of ANE, DADS regulates rather than investigates. DADS Regulatory Services is responsible for monitoring provider compliance of state and federal regulations and facilitating DFPS investigations. In state contracted facilities or services, a provider's unwillingness to cooperate with a DFPS investigation can lead to a variety of sanctions including contract cancellation, license revocation or suspension, decertification, and administrative or civil penalties.[45] Privately operated ICFs/MR are not investigated by DFPS. Under federal regulation, they must report allegations of

[44] Department of Aging and Disability Services, *Follow-up to the House Select Committee on Services for Individuals Eligible for Intermediate Care Facility Services,* (February 12, 2008), Attachment 1, p 1-2.
[45] *Ibid,* Attachment 1, p 1-2.

abuse, neglect, and exploitation to DADS and complete their own investigation.[46] Texas law does not address DFPS' independent investigations of these facilities.

DADS and DFPS have a workgroup studying the lack of service specific data regarding abuse, neglect, and exploitation in community settings, specifically within the HCS waiver program. HCS is an umbrella waiver program that contains a number of services including residential assistance, day habilitation, counseling, nursing, and respite. The workgroup has been tasked with researching ways to update DFPS' current system to extract data by HCS service type. When DFPS responds to an allegation of ANE in the HCS setting, it is responsible for investigating whether the allegation is confirmed and reporting its findings to DADS. While the IMPACT system has data on the provider and the address of the alleged ANE, the system was not designed to support the type of data extraction now necessitated by the complexity of HCS programs. The database does not allow for the entry of information regarding specific services administered by the provider at the time of the alleged incident. Historically, services were provided for entirely by the state, allowing for the more detailed data trending available for state schools.

Department's Efforts to Convert to Community Based Care

When a consumer wishes to receive ICF services in the community, he/she places his/her name on an interest (waiting) list. These waiver services are provided on a first-come, first served basis. These lists do not consider the consumer's needs and eligibility for the

[46] *Ibid,* Attachment: Intermediate Care Facilities for Persons with Mental Retardation, November 2007.

waivers is not established until the consumer's name rises to the top of this list. Many individuals on individual interest lists receive some support services including services in another waiver. For example, some consumers on the CLASS waiver are on the HCS waiting list because there is a residential component to the waiver. As of June 2008, the unduplicated count of persons in all Medicaid 1915(c) waivers is 82,050.[47] This number includes waivers that waive-off ICF services and those that waive-off nursing home services. DADS' method of handling the interest lists makes it difficult or impossible to accurately determine how many people on the interest list are ineligible for services.

In recent years, increasing the service and living options for individuals with intellectual and developmental disabilities is an issue that has received considerable attention from both the U.S. Supreme Court and the Texas Legislature. In 2002, Governor Rick Perry issued executive order RP-13, directing the HHSC to review and correct state policies that create barrier for individuals wishing to move from an institutional setting to the community, address housing and employment issues, ensure child permanency planning, and add an essential services waiver for individuals on HCS waiver waitlists. More recently, in an effort to increase transparency and decrease potential conflict of interest, Senate Bill 27, 80th Legislature, delegated the Community Living Options Process to the local MRAs, a task DADS previously performed. The new process became operational in January 2008.

[47] Adelaide Horn, Department of Aging and Disability Services, *Testimony before the Senate Committee on Health and Human Services*, (Austin, TX, September 17).

Since the beginning of the initiative, reducing the number of individuals on the community-based services interest lists has been a primary focus. The 79th Legislature appropriated $97.9 million in General Revenue funds to DADS to reduce the number of individuals on interest lists. Using this funding, DADS could authorize another 8,891 individuals into the Medicaid 1915(c) waiver services (CBA, CLASS, DBMD, HCS, and MDCP).[48] DADS received $71.5 million in general revenue funds appropriated by the 80th Legislature to reduce its waiver interest lists by expanding waiver program services to an additional 8,902 people.[49] Although the Legislature made a significant commitment to decrease the interest lists for persons wishing to receive waiver services, these lists continue to grow.

The Texas Promoting Independence initiative, known as one of the most proactive in the nation, began in January 2000, at which time the HHSC, in accordance with executive order GWB 99-2, reviewed all disability services and support systems in the state in order to improve the information available about community supports. Since the initiative began, Texas has seen a significant reduction in the number of institutionalized individuals. From 2000 to 2006, the number of institutionalized residents dropped from 76,350 to 69,032.[50] Under this plan, persons who reside in state schools may move into

[48] Texas Health and Human Services Commission, *The 2006 Revised Texas Promoting Independence Plan in Response to S.B 367, 77th Legislative Session, Executive Order RP-13, and the Olmstead Decision*. (February 2007) Available at: http://www.dads.state.tx.us/providers/pi/2006PromotingIndependencePlan.pdf, Accessed: July 2008.
[49] Adelaide Horn, Department of Aging and Disability Services, *Testimony before the Senate Committee on Health and Human Services*, (Austin, TX, September 17, 2008).
[50] Texas Health and Human Services Commission, *The 2006 Revised Texas Promoting Independence Plan in Response to S.B 367, 77th Legislative Session, Executive Order RP-13, and the Olmstead Decision* p. 7, (February 2007). Available:http://www.dads.state.tx.us/providers/pi/2006PromotingIndependencePlan.pdf, Accessed: July 2008.

the community within six months of a referral and persons who reside in large ICFs-MR may move into the community within twelve months.[51]

The Money Follows the Person (MFP) initiative, which began in 2001, assists individuals residing in a nursing facility to return to the community without waiting on an interest list and allows their entitlement dollars to be used for community based services. The initiative has assisted over 12,000 individuals to transition to the community. Over the next five years, HHSC and DADS plan to use the $18 million federal Money Follows the Person demonstration award to expand Texas' existing MFP initiative to include individuals with developmental disabilities and behavioral health needs.

As part of this new federal initiative, Texas will also receive an enhanced Medicaid match rate of 80 percent for individuals participating in the demonstration project. Specifically, Texas plans to target individuals currently residing in ICFs/MR with 14 plus beds by allowing expedited access to HCS waiver services, and individuals living in 9-plus bed ICFs/MR through the voluntary closure of these facilities and transitioning of their residents to the community.[52] The demonstration also includes a pilot for up to 50 participants who have both substance abuse and mental illness to transition from nursing homes to the community.[53] There are also plans to work with public housing authorities

[51] Adelaide Horn, Department of Aging and Disability Services, *Testimony before the Senate Committee on Health and Human Services*, (Austin, TX, September 17, 2008).
[52] Department of Aging and Disability Services, *Money Follows the Person Demonstration Project.* Available: http://www.dads.state.tx.us/providers/pi/mfp_demonstration/index.html, Accessed July 24, 2008.
[53] Adelaide Horn, Department of Aging and Disability Services, *Testimony before the Senate Committee on Health and Human Services*, (Austin, TX, September 17, 2008).

to connect the community based services and supports with the housing system.[54] Over the next five years, the agencies hope to transition another 2,600 individuals through the federal demonstration project.[55]

Conclusion

DADS must ensure the safety of citizens in its care by fulfilling the requirements set forth in its improvement plans for state schools and waiver programs. In addition, DADS should continue strengthening these plans in order to provide quality services. In the 81st session, the Legislature should consider legislation to better serve Texans with disabilities, including the following recommendations.

Recommendations

1. **Develop a long range plan to decrease the wait time for Medicaid 1915(c) waiver services.**

   Rationale: This would provide consumers and their families with a true choice. The Legislature should review and amend the entitlement and waiver residential settings and eligibility criteria. The Legislature should also ensure that waiver options are available for those facing institutionalization.

[54] Department of Aging and Disability Services, *Money Follows the Person Demonstration (Demonstration),* Available*:* http://www.dads.state.tx.us/news_info/faqs_fact/MFPDemonstration-factsheet.pdf. Accessed: July 24, 2008.
[55] *Ibid*.

2. **DADS should improve documentation of the community living options information process (CLOIP).**

   Rationale: This would ensure that consumers receive the information they need in order to make an informed choice about their living arrangements. Although MRAs now administer the CLOIP process, DADS should ensure that it adequately documents discussions.

3. **Require DADS to give clear notice to consumers and guardians regarding how to appeal a decision from DADS that denies consumer preference on community living options.**

   Rationale: The state auditor revealed deficiencies with this process. Consumers and guardians must be made aware of their rights to an appeal.

4. **DADS and DFPS should strengthen their processes and timeliness for investigations of abuse and neglect complaints at state schools, community ICF/MRs, and waiver programs.**

   Rationale: The state auditor revealed that both agencies were inconsistent in investigating abuse and neglect. Improving timeliness to meet required benchmarks would ensure that consumers are not in continued contact with an alleged perpetrator or abuser.

5. **Require DFPS to investigate instances of abuse in community ICF/MRs.**

   Rationale: This would ensure that investigations are independently and thoroughly investigated. DFPS currently investigates abuse and neglect in all other ICF related facilities and services including state schools and waiver programs.

6. **Require DADS and DFPS to place abuse/neglect statistics on the Long Term Care Quality Reporting System (QRS) website for waiver providers.**

   Rationale: This would help consumers and guardians make informed provider decisions. QRS already provides complaint information for nursing homes, assisted living facilities, community ICFs and state schools.

7. **DADS should evaluate whether state schools could provide outpatient services to developmentally disabled individuals living in the community.**

   Rationale: Consumers in rural areas of the state have limited access to specialty providers. This recommendation could eliminate barriers that prevent a person from living in the community. Wyoming and Mississippi state schools offer such options.

8. **Implement a Medicaid Buy-In Program for Children with Disabilities.**

   Rationale: This would enable families to gain access to affordable and adequate health coverage. Many families with disabled children are unable to

buy health insurance because of their children's complex medical needs.

9. **Consider designating one state school for all court commitments and revising entry criteria for that population.**

   Rationale: This would ensure the safety of other consumers living in state schools and ensure the appropriate placement of court commitments.

Charge 2: Medicaid Outcome-Based Reimbursement

Study and make recommendations related to creating an outcome-based reimbursement model in Texas' Medicaid program as a way to improve quality of care, reduce medical errors, and create cost savings. Develop a pilot health care program that pays for best practices, rather than only paying for actual procedures performed. Examine the Centers for Medicare and Medicaid's (CMS) efforts to create an outcome-based system in the Medicare payment system that sanctions serious, preventable medical errors. Examine Pennsylvania's efforts to implement a similar outcome-based reimbursement model to make providers more vigilant about patient care, encourage best practices, and reduce costs in their Medicaid program. If necessary, examine other health care coverage models that have successfully incorporated an outcome-based reimbursement system. Consider pay-for-performance, options that reward good outcomes and the use of best practices, and changes to the reimbursement system that will reduce serious preventable medical errors and hospital acquired infections.

Background

Medicaid is funded by both the state and federal government and administered by the Texas Health and Human Services Commission (HHSC). Medicaid pays for health care services for low income families, non-disabled children, relative caretakers of dependent children, pregnant women, the elderly, and people with disabilities. Statistics indicate that 25.1 percent, or 5.6 million, of Texans are without health insurance, which is the

highest uninsured rate in the nation. At any given moment throughout the year, 8.5 million Texans will go without health insurance.[1] Texas Medicaid enrollment has increased by one million people over the past five years.[2] Of those Texans provided with Medicaid, two-thirds are children and the remaining one-third are elderly and patients with disabilities.[3] With the increase of Medicaid enrollment and state costs, Medicaid reform has become a legislative priority issue in the legislative arena.

Pay-for-performance (also known as outcome-based reimbursement, value-based purchasing, and evidence-based purchasing) is an approach to reimbursing health care providers with incentive strategies that encourage quality, efficiency, and effectiveness. As the cost of health care has increased, purchasers of health care services have sought to create mechanisms to construct a more direct link from health care payments to quality provision of health care, to ensure that limited financial resources are used more effectively. The movement for pay-for-performance in health care began with the private sector in the 1990s.[4] In a national survey, 52 percent of private pay Health Maintenance Organizations (HMOs), which cover 81% of enrollees, report using pay-for-performance measures.[5] The move toward quality-centered provision of services functioned well for private insurers as they were most likely to see the direct results of the ineffective care and inefficiencies in the provision of health care services for their enrollees. As private

[1] Task Force for Access to Health Care in Texas, *Code Red: The Critical Condition of Health in Texas*. Available: http://www.coderedtexas.org/files/code_red_synopsis.pdf, Accessed: November 2008.
[2] Texas Medical Association, *Federal Medicaid Reform.* Available: http://www.texmed.org/Template.aspx?id=3727, Accessed: November 2008.
[3] *Ibid*.
[4] Plexis Healthcare Systems, Inc. White Paper. "Pay-for-performance: Improving Quality and Efficiency of Health Delivery," Available: http://www.plexisweb.com/info/whitePapers/p4atpdf, Accessed: November 2008.
[5] Rosenthal MB, et al. "Pay-for-Performance in Commercial HMOs". New England Journal of Medicine, Nov 2, 2006 355 (18):1895-1902.

insurers realized that they must take steps to improve care, they began aligning payments and incentives with quality services that would improve the health of enrollees and increase the effectiveness of the HMO.

The modern pay-for-performance model began with a 2001 Institute of Medicine (IOM) report that recommended incentive payments to improve quality in the healthcare system.[6] The report focused on reinventing the delivery of healthcare and laid out a comprehensive strategy by which government, health care providers, industry, and consumers could accomplish this goal. The report focused on five initiatives:

1. reducing medical errors;[7]
2. collecting clinical practice variation and acute treatment data;
3. publishing quality and cost data and applying evidence to health care delivery;
4. aligning payment policies with quality improvement; and
5. using information technology to facilitate communication between treatment providers.[8]

Following the publication of the IOM report, CMS launched its pay-for-performance program, the Medicare Hospital Quality Initiative (HQI), in 2001. The goals of this initiative were to improve the care provided to Medicare beneficiaries by the nation's hospitals. The HQI outlined quality measures, including clinical rates of medical errors, and patient information that would indicate the improvement in the quality of healthcare.[9]

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[6] "Crossing the Quality Chasm," Institute of Medicine, March 2001, Available: http://www.iom.edu/Object.File/Master/27/184/Chasm-8pager.pdf, Accessed: November 2008.
[7] *Ibid*. at 3.
[8] *Ibid*. at 5.
[9] CMS Hospital Quality Initiative Overview, Available: http://www.cms.hhs.gov/HospitalQualityInits/Downloads/Hospitaloverview.pdf, Accessed: November 2008.

Recent Legislation

In recent years, Texas has taken many steps to reform Medicaid through the implementation of various programs. The 80th Legislature enacted Senate Bill 10 which included some outcome-based measures. Additionally, Senate Bill 10, House Bill 1066, and Senate Bill 288 included measures on electronic health technology and reporting mechanisms which would make a pay-for-performance program feasible. During the 79th legislative session, the legislature focused on administrative streamlining and expanding access by passing Senate Bill 1188, which enacted recommendations made by the Governor's Task Force on Medicaid reform, the Senate Committee on Health and Human Services, and others.[10]

Senate Bill 10

Senate Bill 10, 80th Legislature, directed HHSC to establish outcome-based performance measures and incentives to be included in each contract between an HMO and HHSC for the provision of health care services procured and managed under a value-based purchasing model. Under the bill's provisions, HHSC could introduce the performance measures and incentives in an incremental fashion. HHSC established a pilot program to require an HMO to provide pay-for-performance opportunities to its provider network to support quality improvement in Medicaid care after determining that the pay-for-performance measures were feasible and cost-effective.

[10] Texas Health and Human Services Committee, *Interim Report to the 79th Legislature* (December 2004), Available: http://www.senate.state.tx.us/75r/senate/commit/c610/downloads/rpt_c610_dec2004.pdf, Accessed: November 2008.

HHSC established pay-for-performance pilots with Superior Health Plan, El Paso First Health Plan, and McKesson Health Plan. The objectives of the pilot programs were to improve the medical home model, increase member utilization of medical check-ups, improve member awareness of benefits and services, and reward providers who demonstrate an increase in timely medical check-ups and other performance measures. HHSC paid bonuses above the Medicaid base rate to providers who met objectives. The McKesson pilot also integrated a pay for participation aspect—HHSC paid providers increased amounts for participating in the pilot and received an additional amount per patient for completing certain clinical performance measures with the patient. HHSC expects data and a draft of the study from the pilot program evaluation by November 2008 and final recommendations on pay-for-performance in mid-December 2008.

Senate Bill 10 also directed HHSC to adopt rules to permit, facilitate, and implement the use of health information technology for the Medicaid program to allow for electronic communication among HHSC, the operating agencies, and the participating provider for eligibility, enrollment, authorization, and verification procedures; the update of practice information by participating providers; and the exchange of recipient health care information, including electronic prescribing and electronic health records.

House Bill 1066 and Senate Bill 288

House Bill 1066, 80th Legislature, established the Texas Health Services Authority, a public nonprofit corporation created to facilitate the electronic exchange of health information. The Authority will promote standards for electronic interaction and establish statewide health information exchange capabilities for electronic laboratory

results, diagnostic studies, and medication histories. The Governor has appointed members to the Authority, but at the writing of this report, the Authority has met once in September 2008.

Senate Bill 288, 80th Legislature, established a reporting system that requires health care facilities to report health care-associated infections to DSHS. DSHS will collect data through a secure, electronic interface from health care facilities to accurately report on patients, allowing for a risk adjustment of the facilities' infection rates. Senate Bill 288 also requires DSHS to make this information available to the public.

Initiatives from the 79th Legislature

Senate Bill 1188, 79th Legislature (2005), sought to improve health outcomes and achieve cost savings by optimizing Medicaid financing, improving data collection and analysis, alleviating administrative burdens for providers, improving case management systems for clients, enhancing the quality of the services, reducing inappropriate utilization of hospital emergency rooms, and coordinating educational outreach about the Medicaid program for both clients and providers. Medicaid program contractors were also directed to analyze current case management, national best practices in case management, waiver feasibility, recommendations for case management optimization, and stakeholder involvement."[11] Rider 60 in the Health and Human Services Commission's appropriation in House Bill 1, 79th Legislature, allows for rewards and

[11] The Texas Health and Human Services Commission, Testimony before the Senate Committee on Health and Human Services, (Austin, Tex., September 19, 2006).

incentives for hospitals that are efficient, cater to Medicaid clients, and control medical costs.[12]

The Deficit Reduction Act

Summary of the Deficit Reduction Act

The Deficit Reduction Act (DRA) passed in 2005 by the federal government gives states new flexibility over benefit design and the development of servers in their Medicaid programs. [13] According to the Texas Health and Human Services Commission, the Deficit Reduction Act will lead to a reduction in federal spending by $39 billion between 2006 and 2010.[14] Medicaid provisions in the Act include reductions in Medicaid direct spending in five major categories: prescription drugs, asset transfer changes for long term care eligibility, fraud, waste, and abuse, cost sharing and flexibility, and state financing.[15] The DRA also required hospitals to begin reporting secondary diagnoses that are present on admission, starting with discharges on or after October 1, 2007. The large amount of anticipated savings is a result of allowing states to impose higher cost sharing requirements and premiums, lower payments for outpatient prescription drugs, and increased penalties for certain acts.[16]

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[12] *Ibid*.
[13] Rosenbaum, Sara and Palmer, Lindsay, "After the Deficit Reduction Act: Using Medicaid to Design Accountable Systems of Care for People with Complex and Special Needs," Center for Health Care Strategies, Inc., Issue Brief, March 2007, Available: http://www.chcs.org/usr_doc/After_the_Deficit_Reduction_Act.pdf, Accessed: November 2008.
[14] Texas Health and Human Services Commission: Deficit Reduction Act Summary. Available: http://www.hhsc.state.tx.us/news/meetings/past/2006/Council/032406_3f.pdf, Accessed: November 2008.
[15] Texas Health and Human Services Commission: Deficit Reduction Act Summary. Available: http://www.hhsc.state.tx.us/news/meetings/past/2006/Council/032406_3f.pdf, Accessed: November 2008.
[16] Congressional Budget Office Cost Estimate: S 1932 - Deficit Reduction Act of 2005. Available: http://www.cbo.gov/ftpdocs/70xx/doc7028/s1932conf.pdf: (Washington DC, January 27, 2006), Accessed: November 2008.

State Financing

Medicaid Transformation Grants will provide up to $75 million for states to encourage innovative approaches, improve efficiency and increase effectiveness in their Medicaid programs. Potential innovative approaches include drug utilization programs, reduction of patient error rates through electronic tools and improvement of access to physician services through university-based hospital clinic systems.

Commercial Pay-for-Performance Programs

While large-scale pay-for-performance programs are relatively new, three commercial programs are among the most well-known in the private sector:

1. The Leapfrog Group is a nationwide group of health care purchasers with an initiative dedicated to public reporting of health quality outcomes and rewarding effective provision of services. Leapfrog also has a program focusing on reporting and rewarding positive outcomes for hospitals that reduce admissions and improve outcomes for 5 modalities that represent 33 percent of hospital admissions;
2. The Bridges to Excellence is a multi-state employer organization created to encourage improvement in the quality of care by employer insurers. The program has three rewards programs: cardiac care, diabetes management, and physician office practice management; and
3. The Integrated Healthcare Association (IHA) is a coalition of health care purchasers and providers in California with performance measures in three areas: prevention and chronic care, patient satisfaction, and information technology

investment. Over 225 physician organizations, and seven health plans representing over eight million enrollees participate in the IHA program.[17]

The IHA, which began in 2002, is perhaps the most established of all the private pay-for-performance programs. Its results for 2006 indicate that:

1. Fifty percent of physician groups showed improvements across all 14 pay-for-performance clinical quality measures;
2. Patient experience ratings have slowly improved since the program's inception, with patients reporting the highest satisfaction levels with their doctor (87 percent) and doctor interaction (88 percent); patients reported the lowest levels of satisfaction in getting appointments with specialists (73 percent), access to care (74 percent), and coordination of care (75 percent).
3. Health plans have already distributed over $145 million in payments to physician groups as a result of meeting pay-for-performance quality measures from 2003 through 2005.[18]

Within the next five years, 85 percent of state Medicaid agencies will have incorporated pay-for-performance programs.[19] As of 2006, 28 state Medicaid agencies were operating one or more pay-for-performance programs.[20] Fifteen state Medicaid agencies planned to start their first programs during that time.[21] State programs often operate more than one

[17] Kuhmerker, Kathryn, "Pay-for-performance in State Medicaid Programs", Report for the Commonwealth Fund, April 2007, at 1.
[18] Integrated Healthcare Association Year 4 Pay-for-performance Results, Available: http://www.iha.org/Year4_2006_P4Presults_vfinal.pdf, Accessed: November 2008.
[19] Supra note 4.
[20] *Ibid*.
[21] *Ibid*.

program and almost 50 percent of existing programs have been in operation for more than five years.[22]

Pay-for-Performance Programs

Successful pay-for-performance programs entail three main components: program measures, program incentives, and electronic health initiatives.

Program Measures

The selection of appropriate measures is key to a successful pay-for-performance program. State Medicaid programs need to identify which performance measures are priorities and what data providers can actually generate. Medicaid programs should select measures that are:

1. relevant to the targeted Medicaid populations;
2. available for standardizing performance data;
3. available frequently;
4. demonstrate areas for improvement;
5. variable enough to demonstrate differences in performance; and
6. relevant to the state's priorities.[23]

States use five types of performance measures, some separately, some in concert with one another. Health Plan Employer Data and Information Set (HEDIS) measures are a set of standardized performance measures maintained by National Committee for Quality

[22] *Ibid*.
[23] Center for Health Care Strategies, Inc., "Physician Pay-for-Performance in Medicaid: A Guide for States," (2007) at 12.

Assurance (NCQA), a private not-for-profit corporation dedicated to evaluating and accrediting the quality of care and service of various types of health care organizations. These measures usually relate to public health goals regarding prevention, primary care, and chronic disease.[24] Examples of HEDIS measures that state Medicaid programs use in their pay-for-performance programs include childhood immunization rates, timelines of prenatal care, cancer screening, and smoking cessation programs.[25] Many states prefer HEDIS measures because they are nationally recognized and are closely aligned with national Medicaid goals. However, a state can only use HEDIS measures on beneficiaries who are continuously enrolled in the Medicaid program because HEDIS measures track health goals that indicate continuous disease and illness processes.[26]

Structural measures indicate how the state's Medicaid program is organized and configured, such as accreditation status, availability of providers, and adoption of health information technology. While these measures can indicate whether a program is providing quality care, they do not directly relate to patient outcomes.[27]

Cost and efficiency measures track the overall spending levels of a program. Sometimes programs measure cost savings or overruns for a Medicaid population. Other times states measure the efficiency of a program activity, such as claims processing, grievance

[24] *Ibid*, at 13.
[25] *Ibid*.
[26] *Ibid*, at 15.
[27] *Ibid*, at 15.

resolution, and notification of beneficiaries.[28] One-third of the Medicaid programs incorporate cost and efficiency measures.[29]

Patient experience of care measures assess patient ratings of the quality of the care and services they receive. Programs incorporating patient experience measures often feature patient surveys and are used frequently in programs related to nursing homes.[30]

States develop measures based on medical records by reviewing information in patient files. This practice is expensive and burdensome. Only four existing pay-for-performance programs use measures based on medical records.[31]

Many pay-for-performance programs rely on administrative data that the programs generate from physician claims data. These data are inexpensive to obtain, yet are particularly subject to inaccurate coding and data entry errors.[32] Additionally, these records do not provide a full clinical picture of services.[33] Clinical data provides the most complete picture of the services provided; however, it is intensive and expensive to obtain and requires the full cooperation of providers and patients to ensure that they have the means and mechanisms to report clinical events.

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[28] *Ibid*, at 16.
[29] *Ibid*.
[30] *Ibid*, at 16.
[31] *Ibid*.
[32] Center for Health Care Strategies, Inc., "Physician Pay-for-Performance in Medicaid: A Guide for States," (2007) at 18.
[33] *Ibid*.

State Medicaid programs should also make efforts to select pay-for-performance measures from standardized, nationally recognized measurements sets. Using nationally validated measurements allows states to shorten the length of time of program design, reduce the challenges of processing data, and reduce some of the need to test and audit the data.[34] In 2007, CMS released a "Guide to Quality Measures: A Compendium," a compilation of nationally recognized quality measures. The National Quality Association and the National Quality Forum also offer their own standardized measures that the two organizations endorse, respectively.[35]

Pay-for-Performance Program Incentives

Incentives are one of the core components of a pay-for-performance program. Limits on finances and resources typically constrain the types, limits, and ability of a state to provide incentives. The types of incentives used in pay-for-performance programs fall into three categories: positive financial incentives, negative financial incentives, and non-financial incentives. Physicians also tend to be much more accepting of measures evidence-based measures that have the approval of national professional organizations.[36]

Positive Financial Incentives

Providers and plans are more receptive to positive financial incentives. Medicaid directors reported that differential reimbursement rates or fees and bonuses were the most

[34] *Ibid*, at 19.
[35] *Ibid*.
[36] *Ibid*.

effective incentive types.[37] Generally a positive financial incentive is viewed more positively by providers and plans when it occurs on a regular, consistent basis.[38] Positive financial incentives must be at least one to three percent of Medicaid revenue to be an effective inducement for change by a provider or plan. The incentive for plans should be at least one percent. Providers are generally induced to act with a three percent incentive.

Bonuses are one-time or periodic financial rewards for achieving specific performance goals and are the most common type of financial incentive. Medicaid programs consider bonuses relatively easy to calculate and award them in a number of ways: per occurrence; for meeting a minimum goal standard; or for percentage of reimbursement rate. Some programs also set a pre-determined maximum number of bonuses to be given annually.[39]

Differential reimbursement rates or fees are a change in the reimbursement rate or fee to reflect achievement of a performance goal. Differential reimbursements are ongoing changes in payment and are smaller than any one bonus payment. Sometimes a state may implement differential reimbursement rates periodically; sometimes the reimbursement rate is modified continuously.[40]

Withholds are only used in managed care and primary care case management pay-for-performance programs. Some Medicaid programs set aside performance-related funding until a provider demonstrates that a standard has been met. Once the provider meets the

[37] Kuhmerker, Kathryn, "Pay-for-performance in State Medicaid Programs", Report for the Commonwealth Fund, April 2007, at 40.
[38] *Ibid*.
[39] *Ibid*, at 24.
[40] *Ibid*, at 25.

performance standard, the Medicaid program releases the funds in the form of bonuses. Withholds can operate in a number of ways:

1. The state may withhold the funds initially and pay them back in the form of bonuses;
2. Unearned withheld funds can be used as secondary bonuses to plans that meet additional performance measures;
3. The state guarantees that a specific percentage of the withheld funds will be returned; or
4. Withheld funds can be returned to the plans with specific direction from the state Medicaid program to improve poor performance.

States use withholds infrequently. Providers and plans perceive withholds as reductions in the payment rate because they typically reduce the base rate to a level below what was formerly considered an appropriate payment level.[41]

Only Tennessee operates a pay-for-performance program that incorporates a grant. Grants allow states to set their priorities and reward providers for devising innovative solutions and addressing the problems. Typically states ask providers for quality improvement proposals through a request for proposal procedure. The state evaluates the proposals and awards the grants.[42]

[41] *Ibid*, at 26.
[42] *Ibid*, at 27.

Negative Financial Incentives

Penalties are the second most frequently used incentives and are applied when a provider fails to meet required performance levels. Many Medicaid directors and providers feel that penalties are detrimental to a good pay-for-performance program, believing that penalties drive providers from pay-for-performance programs. Implementation methods for penalties include liquidated damages, repayment of administrative fees, reduction in the percentage of reimbursement rate when a standard is unmet, or refusal of payment for poor outcomes.[43]

In its 1999 report, *To Err is Human: Building a Safer Health System*, the Institute of Medicine (IOM) concluded that medical errors, particularly hospital-acquired conditions (HACs), may be responsible for as many as 98,000 deaths annually at costs of up to $29 billion. In 2000, the Centers for Disease Control and Prevention (CDC) estimated that hospital-acquired infections added nearly $5 billion to hospital costs. The director of CMS, Kerry Weems, stated, "Medicare can and should take the lead in encouraging hospitals to improve the safety and quality of care and make better practices a routine part of the care they provide not just to people with Medicare, but to every patient they treat."[44]

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[43] *Ibid*, at 24.

[44] CMS Press Release, "CMS Proposes To Expand Quality Program For Hospital Inpatient Services In FY 2009," April 14, 2008, Available: http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3041&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=false&cboOrder=date, Accessed: November 2008.

In October 2007, CMS issued a regulation stating that, beginning October 1, 2008, it would deny Medicare payments for eight conditions that should never happen. These conditions are termed "never events." CMS will not reimburse hospitals for the added cost of care for the eight conditions, including three serious preventable events unless they were present on admission. The first eight conditions, selected last year because they greatly complicate the treatment of the illness or injury that caused the hospitalization, resulting in higher payments to the hospital for the patient's care by both Medicare and the patient, are objects left in the patient after surgery; air embolism; blood incompatibility; catheter-associated infections; pressure ulcers; surgical site infections; and hospital-acquired injuries including falls, fractures, dislocations, and burns. CMS has proposed expanding the list of conditions in 2009 to include pneumonia, Staphylococcus aureus septicemia, Clostridium difficile associated disease, pneumothorax, deep vein thrombosis, and pulmonary embolism.[45] Currently, the proposed expanded list is posted for public comment.

Other states have begun to follow suit by denying Medicaid payments for never events. On January 14, 2008, Pennsylvania stated that it will begin denying payments on 27 of the 28 serious reportable events that NQF has determined should never occur in a hospital.[46] The state will assess each case for a possible error and look for events that were preventable, within the hospital's control, and resulted in significant harm. On June 5, 2008, New York adopted a list of 14 non-reimburseable never events that will not be

[45] *Ibid*.
[46] PA Medical Assistance Bulletin, 01-07-11, Available: http://www.dpw.state.pa.us/PubsFormsReports/NewsletterSenateBillulletins/003673169.aspx?BulletinId=4300, Accessed: November 2008.

reimbursed after October 1, 2008. Since 2003, Minnesota has required hospitals to report a total of 28 never events, an approach that California also initiated in 2006. Many other states have indicated that they are considering adopting never events reporting requirements.

Non-financial Incentives

In some states, Medicaid beneficiaries receive care through a managed care plan. If beneficiaries do not choose a plan or provider, the state assigns a plan to the beneficiary. Some states that use quality measures in their pay-for-performance analysis auto-assign Medicaid beneficiaries to high performing health plans or providers. Many plans and providers find this a highly desirable incentive because they believe that a beneficiary who does not make a plan choice is less likely to use services.[47] The majority of Medicaid directors found auto-assignment to be only a "somewhat effective" incentive.[48] This incentive is most effective in large states with many plans where providers would be motivated by the competition for increased patient volume.[49] However, in any auto-assignment program the state Medicaid program must be certain that the managed care plan can handle the resulting increased patient volume. Auto-assignment has an additional benefit of entailing no additional cost for a state Medicaid program.[50]

Many states publish a quality ranking of plans and providers. Plans and providers respond to the public rating of their quality and how they rate against their peers. Some

[47] Center for Health Care Strategies, Inc., "Physician Pay-for-Performance in Medicaid: A Guide for States," (2007) at 19.
[48] Kuhmerker, Kathryn, "Pay-for-performance in State Medicaid Programs", Report for the Commonwealth Fund, April 2007, at 41.
[49] *Ibid*.
[50] *Ibid*.

states use "report cards" sent to Medicaid beneficiaries at the time that beneficiaries are required to make a plan or provider choice. Other states publish plan rankings via websites. Rankings can also be made to provider and plan industry organizations; states used this approach with managed care and primary care providers. Some states issue press releases or awards to quality performers. States also recognize high performers without ranking them; this is often used in smaller states with fewer providers. In states that publish quality rankings, Medicaid beneficiaries report not being motivated by these rankings. However, providers and plans report being highly motivated to improve their performance.[51]

Several states or their contractors offer practice management tools to providers such as software for billing and patient management. This often occurs as part of a pay for participation program, in which states offer incentives to providers to report quality measures and engage in pay-for-performance programs.[52]

Michigan ranks plans based on their performance in a program known as initial bid ranking. The state ranks all of the plans that meet the required performance standards, then contracts with enough top providing plans to provide sufficient access to medical care.[53]

[51] *Ibid.*
[52] *Ibid*.
[53] *Ibid*.

Health Information Technology

Health information technology (HIT) is at the center of many pay-for-performance programs. Pennsylvania and Alabama incorporate HIT in their pay-for-performance programs and Alaska, Arizona, Massachusetts, Minnesota, New York, and Utah plan to incorporate HIT into their pay-for-performance programs. To promote adoption of HIT, some states have established pay for participation programs. HIT, including electronic health records, registries, and health information exchanges, can assist Medicaid programs in collecting performance data. Furthermore, the use of HIT allows Medicaid programs to award bonuses and incentives more quickly and efficiently.

CMS currently has a demonstration pilot which will attempt to reveal that use of standardized electronic health records (EHRs) will reduce medical errors and improve quality of care. The project will last five years and will provide financial incentives to 1,200 physician practices in twelve communities. Participants in the study will receive financial incentives for the use and adoption of standardized EHRs for Medicare patients. The pilot will also assess the effectiveness of incentive payments in encouraging adoption and use of EHRs.[54]

[54] CMS News Release "HHS Secretary Announces 12 Communities Selected to Advance Use of Electronic Health Records in First Ever National Demonstration," June 10, 2008, Available: http://www.hhs.gov/news/press/2008pres/06/20080610a.html, Accessed: November 2008.

Medicaid Pay-for-Performance Reform in Other States

Pennsylvania Pay-for-Performance Initiatives

Pennsylvania has implemented a pay-for-performance Medicaid program that is focused in four areas. The first, discussed above, is denial of Medicaid reimbursement to providers for medical errors and poor outcomes.

The second area is a pay-for-performance program, begun in 2005, rewarding quality care and participation in disease management programs for primary care physicians operating within the Medicaid medical home program. Pennsylvania provides payment to providers to: assist with enrollment of eligible patients in the disease management programs, collaborate in care management in disease management programs, and deliver key interventions.[55] Providers in this program receive bonuses through a pay-for-process allocation, in which they receive a bonus for every eligible patient that the physician processes through the disease management program.[56] Pennsylvania has seen an improvement in the health care of patients enrolled in the disease management program and has seen a marked improvement in patient monitoring of their own health care.[57]

The third area of Pennsylvania's pay-for-performance initiatives is a hospital incentive program, begun in 2005. The program rewards management of chronic diseases, management of drug therapies, coordination between health care providers, and

[55] David Kelley, Pennsylvania's Pay-for-performance Programs in Medical Assistance, pg. 4.
[56] *Ibid*, at 5.
[57] *Ibid*, at 8.

investment in quality related infrastructure.[58] Pennsylvania limited participation in this program to hospitals receiving DSH payments. Hospitals were scored on their ability to meet or exceed the above criteria, including the rate of re-admittance following a procedure.[59] The state allocated $1 million for the program and provided grants of up to $100,000 to hospitals that made improvements in care. After the first year, Pennsylvania awarded grants to 19 of 34 hospitals in the program. Thirteen of the grants focused on health information technology development and the remainder focused on improving care coordination.[60]

The fourth area is a pay-for-performance program, implemented in 2005, to motivate managed care plans to make improvements on 10 HEDIS measures. The Pennsylvania Department of Health identified areas for improvement and aligned financial incentives based on specific goals for the managed care plan.[61] The HEDIS measures tracked by the state relate to blood pressure and cholesterol management, diabetes management, cancer screening, prenatal care, appropriate use of asthma medication, and adolescent well-care visits.[62] Pennsylvania set the goals in a manner that made plans eligible for a reward if they were in the top 50 percent of providers or had a statistically significant increase. Plans can only receive awards if they reach the goal. If plans are in the top 50 percent of providers they will receive awards on a sliding scale: 90 percent and above receive the full award, between 75 and 90 percent receive 75 percent of the award, and between 50

[58] *Ibid*, at 12.
[59] *Ibid*, at 13.
[60] *Ibid*, at 20.
[61] *Ibid*, at 21.
[62] *Ibid*, at 22.

and 75 percent receive 50 percent of the award.[63] In 2006, providers were only able to earn less than half of the money set aside for bonuses and awards.[64]

Pennsylvania has learned a number of lessons about its pay-for-performance programs. Medicaid officials have stated that they would continue to foster the use of HIT. The disease management program needs better incentives for pediatric providers. The disease management program also needs to better align provider and consumer incentives. Officials also learned that, for the managed care program, it is important to use nationally accepted measures. They also learned that it is also very important to meet and discuss goals with managed care organizations. Despite some of these impediments, Pennsylvania's programs have seen an improvement in the quality of care and improvement in patient health.[65]

Maine

Maine established a pay-for-performance program in 1998 as part of its primary care case management program. It tracks physician performance data as a non-financial incentive that physicians can use to improve the quality of the care they deliver. The state links the physician performance data to monetary rewards. The legislature established an annual budget of $3 million to be used for bonuses to primary care physicians who show the best performance on a series of measures related to access, emergency room utilization, and preventative care. Physicians in the top 80 percent receive a quarterly bonus payment.

[63] *Ibid*, at 24.
[64] *Ibid*, at 25.
[65] *Ibid*, at 36.

The staff of the Maine Medicaid program report that physicians appreciate the profile reports and pay close attention to the scores and rankings.[66]

Massachusetts

Massachusetts has profiled physician care since 1995 as part of its primary care case management program. The program only applies to physician practices that treat 200 or more Medicaid enrollees. These practices serve 83 percent of the primary care case management program population. The state Medicaid program profiles physicians on HEDIS measures and issues reports based upon this data. Providers are required to implement action plans based on the profile results. More than half of the physician practices in the program reported redesigning aspects of their practice to fulfill the action plan suggestions.[67]

California

In 2003, California instituted a performance based auto-assignment program as part of their Medicaid program. The program auto-assigns Medicaid enrollees to providers who score well on key HEDIS quality measures that include childhood immunization, well-child visits, timeliness of prenatal care, and appropriate use of medications for people with asthma. The auto-assignment program was a creative non-financial incentive that represented powerful motivation to the providers to improve quality.[68]

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[66] Center for Health Care Strategies, Inc., "Physician Pay-for-Performance in Medicaid: A Guide for States," (2007) at 9.
[67] *Ibid*, at 10.
[68] *Ibid*, at 11.

New York

The Medicaid program in New York developed a pay-for-performance program in 2002 that combined financial bonuses for health plans and performance-based auto-assignment. The program evaluates health plans on HEDIS quality measures. Based on their score, each health plan has the potential to qualify for varying levels of incentives that mix financial incentives and auto-assignments.[69]

Rhode Island

In 1998, Rhode Island's Medicaid program created a pay-for-performance incentive program to improve quality, access to care, and decrease medical costs. It evaluates performance based on HEDIS measures, which are externally audited and compared to national benchmarks. It focuses on the importance of "medical homes" and encourages health plans to enact programs and measures to improve disease management and the medical home model of health care. Health plans in the 90th percentile receive a full Medicaid payment. In 2005, the program included a $0.95 per member per month bonus payment to physicians to increase access to primary care and reduce emergency room use. The state gives the payment to the health plans and requires the plans to pass the incentive on to the primary care physicians.[70]

[69] *Ibid*, at 16.
[70] *Ibid*, at 17.

Potential Pay-for-Performance Initiatives in Texas

Texas Hospital Association

In June 2008, the Texas Hospital Association (THA) announced that it had created five principles which it hoped would guide hospitals in developing their own internal policies regarding billing for care related to a serious adverse event. While THA believes that most "never events" lie beyond the control of hospitals and their employees, the five principles create accountability for events within a hospital's control. The five principles are:

1. The error or event must be preventable;
2. The error or event must be within the control of the hospital;
3. The error or event must be the result of a mistake made in the hospital;
4. The error or event must result in significant harm; and
5. The error or event must be clearly and precisely defined in advance.

The THA policy is completely voluntary and a hospital's failure to comply with the principles does not result in any sanctions, penalties, or repercussions.

3M System

3M Health Information Systems offers a system that consists of a billing and administrative process for classifying patient diagnoses that adjusts for severity of illness and risk of mortality. 3M stated that its system is different from the CMS system of classifying medical errors and other systems because other systems do not factor in severe illness. The company contends that this distinction makes it easier to reward providers in any pay-for-performance program. While no states have implemented the

full 3M system, 3M expects that at least one state will completely implement the full system by 2009.

3M estimates that Texas could save between $94.5 and $189 million from the Medicaid program in all funds if the state institutes the company's program. The separate components that 3M uses to compose its system result in a few million dollars of savings each. HHSC has not verified whether these estimates are accurate. 3M also suggests that if its system is initially costly, the state could use Medicaid Disproportionate Share Hospital (DSH) and Upper Limit Payment (UPL) funds as a stopgap to cover the lost funds.

Conclusion

Pay-for-performance programs are relatively new in the realm of provision of health care services. The focus of these programs is to align the money spent on health care with best practices and quality outcomes. If these programs work as discussed, the cost savings and improvement to the quality of health care could be motivation for all states to include some pay-for-performance measures in their Medicaid programs.

Recommendations

1. **HHSC should consider regulations to deny Medicaid payments for preventable medical errors (never events).**

   Rationale: HHSC should focus Medicaid funds on providing care rather than paying for improper care and preventable errors.

2. **Hospitals should not pass on the cost for unpaid never events to patients.**

   Rationale: Patients should not be forced to pay for medical errors due to no fault of their own.

3. **HHSC should consider expanding the SB 10 pay-for-performance pilot programs to other health plans in the Medicaid program.**

   Rationale: If found to be beneficial, the initiatives of the pilot should be replicated throughout the Medicaid program to decrease costs and improve the health outcomes.

4. **HHSC should consider an incentive program to encourage providers adopt and use electronic HIT systems, including expansion of the StarHealth Health Passport program to all children enrolled in the Medicaid program.**

   Rationale: The use of HIT promotes improved health outcomes and enables Medicaid programs to award bonuses and incentives more quickly and efficiently. Expansion of the StarHealth Health Passport will allow the Medicaid program to build upon an already existing program and avoid duplication.

5. **HHSC should consider requiring all Medicaid providers check the Medicaid patient's electronic medication history before providing service.**

   Rationale: Encouraging providers to check electronic medication histories before providing service would promote better health outcome and encourage larger use of electronic HIT.

Charge 3: Resiliency and Disease Management

Study the effectiveness of the Resiliency and Disease Management (RDM) program in the mental health service delivery system, implementation of changes to the crisis care program, and recommendations for appropriate use of the mental health transformation grant. Identify strategies to increase access to services and meet future demand for services. Examine resource allocation and opportunities to maximize funding. Policy recommendations should maximize the number of inpatient psychiatric acute care beds, enhance access to outpatient services, promote the use of recovery-based services, and enhance access to community-based services.

RDM Initiative

Background

In 2003, the 78th Legislature enacted House Bill 2292, which mandated a major Health and Human Services reorganization.[1] HB 2292 reorganized the agencies that provided services, creating the Health and Human Services Commission (HHSC) to oversee four HHS department-level agencies: the Department of State Health Services (DSHS), the Department of Assistive and Rehabilitative Services, the Department of Aging and Disability Services, and the Department of Family and Protective Services. Among its many provisions, HB 2292 directed DSHS to develop a disease-management system.[2] The Resiliency and Disease Management initiative (RDM) is an effort to redesign the delivery of mental health services to adults with severe and persistent mental illness and

[1] Texas House of Representatives, House Bill 2292, 78th Legislature, 2003.
[2] *Ibid*.

children with severe emotional disturbance. The RDM initiative attempts to match services to mental health consumers' needs, and to use resources effectively. The RDM initiative consists of mental health care that provides:

1. A uniform assessment of the needs of consumers, recommend appropriate services based on identified needs, and monitor individual outcomes.
2. A service package for both children and adults that ensures the provision of evidence-based services to those individuals who would most benefit from those services.
3. The ability for Local Mental Health Authorities (LMHAs) to manage limited resources and ensure reasonable access to effective services.
4. Performance contracts between DSHS and the LMHAs that stipulate the service targets, performance measures, outcomes, and remedies, sanctions, and penalties that may result from failing to fulfill contract expectations.
5. The development of a process to assess the reliability of the providers, the MH Authority, and the state agency.
6. The creation of data management tools to monitor the data for decision-making about care and analyze the cost information.[3]

DSHS delegates to community mental health centers the responsibilities of a LMHA which ensures the provision and continuity of services for individuals with mental illness, efficient use of resources, consumer satisfaction, and accountability. Texas has 39 mental health and mental retardation (MH/MR) service areas that provide community-based services combined with the ten state hospitals when intense, inpatient treatment is

[3] Department of State Health Services, Resiliency and Disease Management, Available: http://www.dshs.state.tx.us/mhprograms/RDM.shtm, Accessed: November 2008.

necessary. The 39 local community MH/MR service areas serve every county in Texas, and have dual roles as both mental health authorities (MHAs) and direct service providers. Under 2292, the MH/MR centers must serve as "providers-of-last-resort" (POLR) and are required to prove that every reasonable attempt has been made to form an appropriate base of private providers.[4]

Community MH/MR centers are required to provide a minimum array of mental health services, including crisis stabilization. Crisis services, essential in providing a complete continuum of care at the community level, treat individuals who could hurt themselves or others, be hurt by others, or could end up in jail or homeless due to worsening symptoms of chronic mental illness.[5] Crisis services are also a common way to gain entry into ongoing mental health services, and are critical in determining whether or not a person will have a positive or negative attitude toward the mental health system.[6] During the past year community MH/MR centers served 29,621 children with severe emotional disturbances and 115,056 adults with serious and persistent mental illness.[7]

Crisis Services

Crisis Services Redesign

During the health and human services restructuring following HB 2292, RDM was implemented without an added crisis services component. Recognizing a need to achieve

[4] Department of State Health Services, Providers of Last Resort, Available: http://www.dshs.state.tx.us/mhcommunity/OverviewPOLR.ppt, Accessed: November 2008.
[5] Department of State Health Services, *Crisis Redesign Services,* p. 3. (August 2006).
[6] *Ibid.*
[7] Dr. David Lakey, Department of State Health Services, *Testimony before the Senate Committee on Health and Human Services*, (Austin, TX, October 13, 2008).

rapid stabilization of crisis situations, DSHS commissioned the Crisis Services Redesign Committee in 2005 to develop recommendations to best meet the needs of Texans with mental health problems. The committee found, despite the changes instituted by HB 2292, that mental health services in Texas were still inadequate, under-funded, and poorly coordinated.

The Committee issued recommendations for a Community Mental Health Crisis Services program that would provide for a range of effective community-based interventions designed to intervene in or avoid crises and the need for hospitalization. These services would include mobile outreach, 23 to 48-hour observation, crisis residential and in-home services, respite event coverage, and transportation of people in crisis to mental health hospitals. Mobile outreach provides on-call crisis workers to respond to, evaluate, and stabilize crisis situations in the community. Twenty-three to 48-hour observation includes initial psychiatric emergency services with extended observation. Respite services provide a temporary home for adults, children, or adolescents to allow time to work through issues that may contribute to the breakdown of the home. The goals of the crisis redesign are to establish better local systems to serve persons in crisis, reduce hospital use of emergency beds, reduce the stress on law enforcement, and improve consumers' access to appropriate services.[8]

A pilot program conducted during the 79th Interim by the Community Mental Health Crisis Services program in Bexar County demonstrated that a statewide crisis services

[8] Department of State Health Services, Texas Mental Health and Substance Abuse Crisis Redesign Report, Available: http://www.dshs.state.tx.us/mhsacsr/PDF/mhsacsr.pdf, Accessed: November 2008.

program could result in 25,800 fewer police officer hours per month and provide needed interventions to consumers. [9] The results of this pilot program encouraged the 80th Legislature to appropriate $82.1 million for the Crisis Services Redesign program for the FY 2008-2009 biennium.[10]

Crisis Services Redesign Initiatives

From the amount appropriated, DSHS used $56 million to improve basic crisis response in all mental health regions and enhanced crisis services in select communities. Basic services comprise mobile outreach and hotline services. Enhanced services include crisis residential and respite services, crisis stabilization units, 48 hour extended observation services, assistance with transportation costs, and crisis intervention teams. DSHS used $3.5 million to improve competency restoration and awarded the funds to 5 sites: Tarrant County MHMR, the Center for Healthcare Services, MHMR Authority of Harris County, Austin-Travis County MHMR, and North Texas Behavioral Health Authority. These funds are used for programs that will help free up bed space in state mental hospitals. DSHS awarded $21.4 million to 15 sites for psychiatric emergency centers, jail diversion and alternatives to hospitalization. Some of the funds were used for an external evaluation of the redesign initiative.[11]

Crisis Services Redesign Evaluation

Rider 69 of House Bill 1 (80th Legislature) required DSHS to engage in an external evaluation of the crisis redesign initiatives. Researchers at Texas A&M serve as the

[9] *Ibid*.
[10] Texas House of Representatives, House Bill 1, 80th Legislature 2007.
[11] Mike Maples, Department of State Health Services, *Testimony before the Senate Committee on Health and Human Services*, (Austin, TX, October 13, 2008).

evaluation team. The evaluation of the progress of the crisis redesign initiative has addressed the state's progress toward four goals:

1. Stakeholder satisfaction with improvements made to the community mental health crisis system.
2. Texans who experience a mental health crisis will be served appropriately and timely.
3. Communities have more local, less restrictive alternatives.
4. Community mental health services will be cost effective.[12]

With the basic crisis services, the evaluation team found that crisis hotlines and mobile crisis outreach teams have improved the delivery of crisis services in community settings; however, hiring delays slowed the development of mobile crisis outreach teams and required compensation to be higher than anticipated. Crisis response has also decreased delays and resulted in faster response times to help treat crisis situations.[13]

Expanded crisis services have been able to create community alternatives to hospitalizations such as therapeutic foster care for children. These funds have also been used to address non-clinical issues that may contribute to crisis, such as short-term housing or transportation. The evaluators report that treatment placement is faster in community settings and that judges have reported declines in involuntary state hospital commitments.[14]

[12] Amanda Jensen-Doss, Texas A&M Evaluation Team, *Testimony before the Senate Committee on Health and Human Services*, (Austin, TX, October 13, 2008).
[13] *Ibid.*
[14] *Ibid.*

The evaluators found that increased funding for crisis services is not sufficient. They concluded that DSHS must invest additional funding in ongoing routine services to prevent the development of a crisis-driven mental health system. Community stakeholders fear a pattern of costly repeated crisis encounters, a growing influx of new crisis consumers that would increase wait lists for routine care for RDM services, and an overtaxed maintenance mental health care system may increase the risk of crisis. The evaluators report that there should be a comparable investment in ongoing services in DSHS's RDM services.

The evaluators report that crisis funds have improved the capacity of local mental health authorities to support community partners who collaborate in handling mental health crises. Crisis funds have improved case coordination, reduced burdens on law enforcement, reduced emergency room wait times, and reduced transportation burdens. However, emergency rooms are still the primary venue for medical screenings and staff still report that hours of time are expended in an effort to help locate available state hospital beds. Additionally, emergency room personnel, law enforcement, and judges report that local crisis capacity is greatly outstripped by demand.[15]

Communities with formalized methods and channels for communication between agencies appear to be more successful at implementing crisis services redesign. The evaluators indicate that community forums promote shared responsibility and investment of resources. However, the evaluators report that confusion about the role of law enforcement remains in many communities. Many communities are unsure about

[15] *Ibid.*

whether law enforcement officers are responsible for transportation and screening of individuals in crisis. Law enforcement officers are reluctant to use warrantless detention. Many communities need more mental health deputies and have difficulty accessing a justice of the peace when needed. Additionally, communities report that there is confusion over the legal requirements for crisis case processing and limited consideration is given to mental health during criminal case proceedings.[16]

At the time of this report, the evaluation team had completed the first phase of the evaluation and expects to publish a report to the Legislature in January 2009. The second phase of the evaluation is expected to be complete in January 2010.[17]

Mental Health Transformation Grant

Mental Health Transformation Grant

In 2002, President Bush established the New Freedom Commission on Mental Health. The purpose of the Commission was to evaluate the inadequacies of the mental health system and address the problems plaguing mental health care. The Commission met with stakeholders and representatives from all 50 states.[18] They were able to identify six goals that all states should address in their mental health systems:

1. Americans understand that mental health is essential to overall health.
2. Mental health care is consumer and family driven.
3. Disparities in mental health services are eliminated.

[16] *Ibid.*
[17] *Ibid.*
[18] President's New Freedom Commission on Mental Health Report, Available: http://www.mentalhealthcommission.gov/reports/FinalReport/toc.html, Accessed: November 2008.

4. Mental health screening, assessment and referral to services are common.
5. Excellent mental health care is delivered and research is accelerated.
6. Technology is used to access mental health care and information.

Recognizing that many state agencies provide redundant, fragmented services for people needing mental health services, Governor Perry applied for a five-year Mental Health Transformation State Incentive Grant (MHT Grant) from the federal Substance Abuse Mental Health Service Administration (SAMHSA). The overarching goal is to improve the state's mental health services and support the development of state infrastructure for implementing the New Freedom Commission goals.

SAMHSA awarded over $13 million in grant funding in October 2005 and a Transformation Work Group (TWG) was formed to work in two primary areas: developing and supporting local behavioral health collaboratives, and using cutting edge technology to change work processes across the TWG agencies. There is also an emphasis on increasing cultural competencies and reducing cultural and geographic health disparities. The TWG is composed of consumers, family members, representatives of the Office of the Governor, the Legislature, and 14 state agencies.[19] The input of this work group is crucial to improvements in the mental health system as a whole; hence, recommendations from the TWG are reflected in this report. The ongoing work of the TWG will play an important role in fine-tuning initiatives necessary to transform mental health policy in Texas.

[19] Department of State Health Services, *Mental Health Transformation in Texas*, Available: http://www.mhtransformation.org/, Accessed: November 2008.

MHT Grant Initiatives

Fiscal year 2006, was a planning year where the TWG assessed state and community needs and created a comprehensive mental health plan. From 2007-2010, DSHS and the TWG will implement the plan. The six areas of focus are:

1. improving consumer, youth, and family infrastructure,
2. prevention and early intervention,
3. developing evidence-based services,
4. workforce development and expansion,
5. improving technology for behavioral health transformation, and
6. improving behavioral health community collaboratives.[20]

Community collaboratives across the state submitted grant applications to DSHS for MHT grant funding to use to address the six focus areas. Seven collaboratives received grant funding:

1. San Antonio used its funding to crate a crisis intervention team training for law enforcement officers.
2. Williamson County utilized funds for hardware and software for the development of an electronic emergency mental health record.
3. Llano Estacado Alliance for Families (LEAF) used grant funds to improve a coordinated network of community-based services and supports that are organized to meet the challenges of children and youth with serious mental health needs and their families and to promote the employment of mental health consumers with area employers.

[20] Supra note 7.

4. Nacogdoches used its grant funding to develop a regional crisis center to address community responses to mental health crises.
5. Dallas devoted its funds to training 750 law enforcement officers to respond to crises.
6. Coastal Bend focused its funds toward integration of care with telemedicine.
7. Tarrant County used funds for implementing evidence-based treatment for children and youth.[21]

Prior to receiving the transformation grant, several data-sharing initiatives were already underway to improve the state-wide service delivery system by increasing communication within, and among, different organizations and health care providers. These information technology efforts have the potential to reduce the inefficient expenditures of funds, and also may contribute to better patient outcomes.

Along with the overarching six focus areas of the MHT grant, the TWG also has seven workgroups that examine statewide efforts on issues of children and adolescents, adults, data and information technology, mental health workforce, housing, consumer voice, and returning veterans and their families. The TWG members contributed information to DSHS about the veterans' mental health services available at their organizations. DSHS expects to publish its report "Behavioral Health Services for Returning Veterans and Their Families: Services, Gaps, and Recommendations" in December 2008. Though not included in the Committee's interim charges, the Committee, at the request of Senator

[21] *Ibid*.

Shapleigh, did address issues of mental health and traumatic brain injury services for returning veterans during the October 13, 2008 hearing.[22]

Grant Evaluation

As part of the MHT Grant, SAMHSA required Texas to engage in an evaluation of the effectiveness of the programs initiated. A team of evaluators from the Lyndon B. Johnson School of Public Affairs at the University of Texas was selected to evaluate the progress of the MHT grant project. The evaluation team has conducted a baseline evaluation of the state agencies involved in the MHT grant and the community collaboratives. The evaluators found a number of issues with the MHT project:

1. The MHT grant funds were not disbursed in a regular and timely fashion from the Texas Health Institute causing most community collaboratives to delay their projects.
2. Consumers in many of the collaboratives were still concerned about the stigma of mental health issues.
3. Transportation options for mental health consumers remain an issue. Many consumers state that in rural areas, transportation is not available to obtain mental health services. Additionally, mental health consumers are not able to be reimbursed for transportation costs to attend collaborative and TWG meetings.
4. Some collaboratives have not established a strong mental health consumer presence in the collaborative.

[22] See summary of the veterans' mental health discussion from the October 13, 2008 hearing in Appendix A.

5. The state is not making the best use of information technology both in terms of planning for IT and use of IT as a means for community collaboration.[23]

In September 2008, the TWG and many of the collaboratives met with representatives from SAMHSA to evaluate the progress of the MHT grant. While the SAMHSA representatives noted the successes of the MHT grant initiatives, they stated that at this point in the grant process DSHS, TWG and the collaboratives should consider the sustainability of the programs. They stated that DSHS should continue to encourage the use of the MHT grant funds to develop a system for mental health infrastructure, not for services and so that Texas can focus its state mental health funds on holistic collaborative efforts to create comprehensive mental health solutions.[24]

Conclusion

Starting with HB 2292, Texas has seen vast improvements in the mental health treatment landscape - improvements that have enhanced care, decreased wait times, improved safety, and reduced costs. Though work remains, Texas has taken great strides in developing solutions and providing treatment and care for the mental health issues of Texans statewide.

Recommendations

1. **DSHS must invest equivalent resources in ongoing routine services to prevent the development of a crisis-driven mental health system.**

[23] Dr. Pat Wong and Gary Chapman, LBJ School of Public Affairs Evaluation Team, *Testimony before the Senate Committee on Health and Human Services*, (Austin, TX, October 13, 2008).
[24] *Ibid*.

Rationale: A crisis-driven mental health system only addresses the most surface and immediate issues, but effective treatment relies on ongoing routine mental health care.

2. **Communities should develop formalized methods and channels for communication between agencies.**

   Rationale: Formalized systems of communication appear to be more successful at implementing crisis services redesign and would enable new community approaches and solutions.

3. **Clarify the role of law enforcement and the legal requirements for crisis case processing.**

   Rationale: Because law enforcement officials typically interact with individuals who are in the midst of crisis, clarifying the roles and requirements of law enforcement would ensure and encourage their participation in the crisis care system.

4. **Increase consumer outreach and support for MHT.**

   Rationale: Consumer organizations and individual consumers need incentives to encourage participation in MHT meetings about implementation and services. An increase in consumer outreach to inform consumers about services and support groups in their area through community level newsletters, informational flyers at providers' offices, and church

organizations ensure that services address consumers' needs. Using MHT funds to provide transportation and childcare assistance supports consumer participation in the MHT process.

5. **Organize MHT consumer organizations by region.**

   Rationale: Regional models of collaboration evaluate consumer organizations at local levels and find successful models. Large local organizations may help local or grassroots organizations to connect organically with one another.

6. **Collaboratives should train local workforce who interact with mental health consumers, including law enforcement.**

   Rationale: Creating a system of training or education for community members related to law enforcement or crisis intervention for mental health consumers will ensure that these community members are involved in mental health transformation.

7. **Encourage collaboratives to facilitate and use telemedicine across their service regions.**

   Rationale: Telemedicine will encourage facilities and physicians in underserved areas to increase consumer access to services.

8. **Hold collaboratives accountable for consumer participation through reporting.**

   Rationale: Some collaboratives have not established a strong consumer presence in the collaborative. Requiring collaboratives to report on consumer participation in the collaborative will ensure that collaboratives incorporate consumer needs and desires in service provision.

9. **Improve transportation options for mental health consumers including mobile treatment/counseling programs.**

   Rationale: In areas with poor public transportation, consumers find it difficult to access services. Methods to access service and treatment need to be available.

10. **Expedite disbursal of funds to the collaboratives.**

    Rationale: Most community collaboratives suffered from delayed dispersal of MHT funds. For sustainability of the mental health transformation process, stable funding and proper supervision is needed.

11. **DSHS needs better strategic planning for IT with more engagement of state IT personnel, particularly Department of Information Resources, with a focus on interoperability and sharing.**

Rationale: Interoperable information technology enables local mental health agencies to interact with DSHS systems as well as other community stakeholder information systems.

12. **The community collaboratives should play a role in guiding state strategy on overall IT use, including electronic health records and state-wide online "learning communities".**

    Rationale: Community collaboratives know firsthand what information and mechanisms are vital to include in mental health information technology to ensure appropriate provision of mental health services.

13. **Communities and state agencies need a more collaborative, unified relationship of two-way communication.**

    Rationale: Collaborative, unified coordination enables DSHS to interact with communities and consumers to better tailor services and assistance to the actual needs of mental health consumers.

Charge # 4: CPS Caseworkers and Caseloads

Monitor the implementation of the Department of Family and Protective Services' improvement plan to reduce caseloads for the Child Protective Services caseworkers, and to provide family-based safety services and ongoing substitute care. Evaluate the efficiency of Child Protective Services "functional units," and determine if other organizational models would allow for a reduction in caseworkers' caseloads, without increasing other administrative costs. Develop recommendations aimed at lowering individual caseloads, making casework more efficient, and improving the retention of caseworkers. Assess the viability of caseworker reimbursement as a manner to lower caseworker turnover.

Background

In 2006, almost one million children in the United States were abused or neglected.[1] These children often enter overburdened state child welfare systems plagued with high caseloads and high employee turnover rates. In a report issued to the U.S. House of Representatives Committee on Ways and Means Subcommittee on Income Security and Family Support, the General Accounting Office (GAO) concluded that caseworker recruitment and retention is one of the most important challenges that state child welfare agencies must address in order to improve outcomes for children and families.[2] High

[1] National Child Abuse and Neglect Data System, Child Maltreatment (2006). Available: http://faq.acf.hhs.gov/cgibin/acfrightnow.cfg/php/enduser/cls_adp.php?p_sid=9l8vDU3j&p_lva=&p_li=&p_accessibility=0&p_search_text=children%27s+bureau&p_sp=Y2hpbGRyZW4ncyBidXJlYXUmcF9zZWFyY2hfdGV4dD1jaGlsZHJlbidzIGJ1cmVhdQ**&p_cluster=0000|52|10038&p_faqid=68&p_created=1001610478&p_topview=1, Accessed: March 2008.

[2] William Bell, *Testimony before the U.S. House of Representatives, Committee on Ways and Means, Subcommittee on Income Security and Family Support*, (May 2007). Available:

employee turnover directly impacts the child welfare agency's financial resources as well as employee productivity and quality. High employee turnover likewise burdens current employees with persistent workflow strain and uncertainty.[3] Texas is not alone in its struggle to retain quality caseworkers. As of 2004, average turnover among child welfare agencies throughout the U.S. was between 30 percent and 40 percent annually, with the average tenure for child welfare workers being less than 2 years.[4] According to the GAO report, caseworkers' desire to remain in the child welfare profession was influenced by high quality supervision and adequate on the job training.[5]

Over the past three years, the Texas Department of Family and Protective Services (DFPS) has made monumental changes in the state's Child Protective Services (CPS). Legislation by both the 79th and 80th Legislatures required significant reforms to both the investigation division and the foster care system. Over $450 million dollars in All Funds was appropriated to further these reforms. A substantial portion of this appropriation was dedicated to increasing the number of direct care staff throughout the system. Although there have been marked improvements, CPS continues to struggle with increasing caseloads in certain divisions and high caseworker turnover rates, both of which can increase the risk of harm to children involved in the child welfare system. Caseworker turnover and increasing caseloads are intrinsically related and DFPS will

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http://www.casey.org/MediaCenter/MediaInterviewsAndSpeeches/BellTestimony15April2007.htm, Accessed: March 2008.

[3] National Council on Crime and Delinquency, Cornerstones for Kids, *Relationship between Staff Turnover, Child Welfare System Functioning, and Recurrent Child Abuse*, (2006).

[4] United States General Accounting Office, *Child Welfare: HHS Could Play a Greater Role in Helping Child Welfare Agencies Recruit and Retain Staff*, p.5 (2004), Available: http://www.gao.gov/new.items/d03357.pdf, Accessed: October 1, 2008.

[5] *Ibid.*

continue struggling with increasing caseloads as long as it is unable to reduce caseworker turnover rates.

Caseworkers

This report references different types of caseworkers. The following is a description of these caseworkers and their duties.

When a report of child abuse or neglect is made, investigative caseworkers are assigned to interview the child, family, and persons with knowledge of the family. Their job is to determine whether child abuse or neglect occurred and to assess the risk of future abuse or neglect. Investigative caseworkers work with their supervisors to either assign the family in-home support services or recommend to the court that a child be removed from his/her home and placed in kinship care or foster care.[6]

If an investigative caseworker recommends that the family be placed in family-based safety services (FBSS), a FBSS caseworker is assigned to that family to work through specific goals in order to reduce the risk of future abuse and neglect. These goals may include parenting classes, home repairs, and/or treatment for substance abuse.

When a court orders that a child be placed in foster or kinship care, that child is assigned a conservatorship or substitute care (CVS) caseworker. CVS caseworkers work with the child and foster/kinship family to ensure that the family provides the child with a safe

[6] Department of Family and Protective Services, *2007 Annual Report p. 7,* Available: http://www.dfps.state.tx.us/About/Data_Books_and_Annual_Reports/2007/annual_report/default.asp, Accessed: May 6, 2008.

living environment and that the child receives adequate medical and therapeutic treatment. CVS caseworkers monitor the child and family until a permanent placement is made, which can include returning the child to his or her biological family or adoption.

Legislation

Senate Bill 6, 79th Legislature (2005) (SB 6), required significant reorganization of the DFPS workload distribution in order to reduce caseloads, enhance accountability and improve the quality of investigations.[7] This improvement plan authorized the use of functional units, tablet personal computers, and mobile dictation services to assist caseworkers. A functional unit consists of five caseworkers, one supervisor, a clerk, and a case aide. These units not only help reduce caseworkers' caseloads, but also provide increased support for the work associated with the cases.[8] The Senate Committee on Health and Human Services Interim Report to the 80th Legislature includes additional details about SB 6 and its improvement plan.[9]

Senate Bill 758, 80th Legislature (2007) (SB 758), was enacted to continue the previous session's CPS reforms.[10] SB 758 focused on reforming the foster care system and required DFPS to develop a CPS improvement plan. Statutorily required goals of the plan include:

1. keeping families together while ensuring child safety in the home;
2. reducing the length of time children remain in state care; and

[7] Texas Senate. Senate Bill 6, Enrolled Version, 79th Legislature, regular session (2005).
[8] Carey Cockerell, Department of Family and Protective Services, *Testimony before the Senate Committee on Health and Human Services*, (Austin, Texas, April 30th 2008).
[9] Senate Committee on Health and Human Services, Report to the 80th Legislature, December, 2005.
[10] Texas Senate. Senate Bill 758, Enrolled Version, 80th Legislature, regular session (2007)

3. improving the quality and accountability of foster care.[11]

The improvement plan also required DFPS to reduce caseworkers' caseloads and provide FBSS and ongoing substitute care services.[12] DFPS was also required to provide the Governor and the Legislature with periodic progress reports on the improvement plan.

SB 758 also included a provision requiring DFPS to evaluate whether staff recruitment and retention would be positively impacted by providing educational reimbursements to caseworkers enrolled in institutions of higher education that provide training in child protective services. This DFPS report is scheduled to be released in December 2008 and will not be available for review prior to the issuance of this report. The bill also required DFPS to implement a hiring preference for caseworkers with a bachelor's degree in a human service-related field, including social work, sociology, criminal justice, psychology, education, or counseling. Studies indicate that retention rates are higher among employees with a bachelor's degree in a human service-related field than among employees with a bachelor's degree in a non-human service-related field. [13]

Recognizing the importance of staff retention, the Legislature also enacted Rider 15 in Senate Bill 1 (79th Legislature) and Rider 13 in House Bill 1 (80th Legislature) to direct

[11] Texas Senate. Senate Bill 758, Enrolled Version, 80th Legislature, regular session (2007)
[12] *Ibid.*
[13] United States General Accounting Office, *Child Welfare: HHS Could Play a Greater Role in Helping Child Welfare Agencies Recruit and Retain Staff*, p.5 (2004), Available: http://www.gao.gov/new.items/d03357.pdf, Accessed: October 1, 2008.

DFPS to develop a Human Resources Management Plan.[14] This management plan spans the entire agency, not just CPS. The Rider states:

Human Resources Management Plan. *From funds appropriated above, the Texas Department of Family and Protective Services shall develop a Human Resources Management Plan designed to improve employee morale and retention. The plan must focus on reducing employee turnover through better management. The Texas Department of Family and Protective Services shall report semi-annually to the Senate Finance Committee, the House Committee on Appropriations, the Legislative Budget Board, and the Governor the employee turnover rate, by job category, at the agency during the preceding twelve months. The effectiveness of the agency's plan shall be measured by whether there is a reduction in employee turnover rates at the agency, specifically by the reduction in the turnover rates for caseworkers.*[15]

The agency's Rider 15 fiscal year (FY) 2007 Human Resources Management Plan includes the following initiatives:

1. Actively pursue the development of policy and implementation of flexible work schedules and/or teleworking/telecommuting for appropriate staff.
2. Expand structures proven to address field staff burnout and stress.
3. In addition to the existing emphasis on case management, expand supervisory development, training and support to increase the focus on human resource management.
4. Increase the agency's capacity to use data to pinpoint barriers to staff retention and use this to pilot a program in which high-performing, high-retention units are paired with and able to mentor units that are less successful.[16]

[14] Department of Family and Protective Services, Rider 13, Human Resource Management Plan, (October 2007). Available: http://www.dfps.state.tx.us/documents/about/pdf/2007-10-19_Rider13.pdf. Accessed: May 21, 2008.
[15] Texas House. House Bill 1. Enrolled versions, 80th Legislative Session. (2007).
[16] Department of Family and Protective Services, Rider 13, Human Resource Management Plan, (October 2007) Available: http://www.dfps.state.tx.us/documents/about/pdf/2007-10-19_Rider13.pdf. Accessed: May 21, 2008.

Although DFPS worked to enact policies to foster better staff retention, it did not see marked results from the above initiatives. Consequently, DFPS has since enacted new initiatives directed at reducing staff turnover. These efforts are reported in the two legislatively mandated Rider 13 reports to the legislature released in October 2007 and April 2008.

Improvement Plan - Caseworkers

Increasing Caseworkers

SB 758 required a reduction in FBSS and CVS caseworkers' caseloads in order to facilitate better safety outcomes for children, whether they continue living in their own homes or in substitute care. House Bill 1, 80th Legislature, allocated additional appropriations to hire 212 new FBSS caseworkers and 372 new conservatorship caseworkers for the biennium.[17] Additional support staff were also hired for these divisions. For families in FBSS, reducing caseloads is designed to improve families' and children's well-being by enabling caseworkers to have more contact with the families.[18]

Additional money for new full-time employees (FTEs) will also enable conservatorship caseworkers to engage in monthly face-to-face contacts with 90% of children in substitute care, in accordance with recent federal legislation requiring states to meet this 90% requirement by 2011.[19] The U.S. Department of Health and Human Services Children's Bureau found that one of the most important ways to promote positive outcomes for children and their families is to ensure the quality and frequency of

[17] Department of Family and Protective Services, *SB 758 Implementation Plan*, p. 6. Available: http://www.dfps.state.tx.us/Documents/About/pdf/2007-12-31_SB758.pdf, Accessed: May 2008.
[18] *Ibid.*
[19] *Ibid.*

caseworker visits with children and families in the agency's care.[20] Adding more conservatorship caseworkers and reducing their caseloads is intended to enable children in substitute care to reach permanency more quickly.

Evaluating Functional Units

Functional units were established to increase caseworker productivity by decreasing the workload associated with each case. Case aides and clerical staff are assigned to functional units to help with the administrative duties previously left to the caseworkers within the investigative, FBSS, and conservatorship divisions under the direction of SB 6. These duties include transporting children to family visits, filing, and certain documentation duties. SB 6 also required new timelines for investigations which would be impossible without a workload distribution plan that streamlines caseworkers' duties and focuses their efforts on CPS' core mission to protect children from abuse and neglect.

The 1:5 ratio of supervisors to caseworkers facilitates better caseworker management and support. According to CPS' Evaluation on Training and Retention Study, employees rated their supervisors' role significantly higher than workers who left DFPS, suggesting that the presence of supportive supervisors who work closely with caseworkers facilitates better job stability and satisfaction. Although functional units were originally created to help investigative, FBSS, and CVS caseworkers, the success of, and worker satisfaction with, functional units provided DFPS with enough information for it to request that the Legislature fund similar units for child care licensing staff.

[20] National Conference of State Legislatures, Report: *Child Welfare Caseworker Visits with Children and Parents Innovations in State Policy,* (September 2006).

Retention Studies

DFPS relies on three workforce retention studies in order to evaluate workforce concerns and develop better workforce policies: the Survey of Organizational Excellence (SOE), the State Auditor's Office Survey on Exiting Employees, and DFPS' quality focus groups.[21] Every two years, the University of Texas at Austin Center for Social Work Research conducts the SOE for all state agencies. The SOE regularly produces a high response rate. In addition, the State Auditor's Office online exit survey provides state agencies with feedback from former employees in order to determine why they leave state employment. Reporting tends to be significantly lower for the State Auditor's survey. Finally, DFPS enacted structured focus groups to enable its employees to provide feedback on workforce strains.[22] Throughout these workforce retention studies, employees cited three top reasons for leaving the DFPS: working conditions/environment, salaries and benefits, and issues with their supervisors.[23]

Workforce Support and Retention Initiative

In DFPS' ongoing effort to retain staff, it developed the Workforce Support and Retention Initiative outlined in the April 2008 Rider 13 report. DFPS' efforts are highlighted in these key initiatives citied in the report:

1. **Manage workloads:** Systematically analyze practices and make recommendations that will increase the efficiency of frontline workers, thus

[21] Department of Family and Protective Services, Rider 13, Human Resource Management Plan, (October 2007). Available: www.dfps.state.tx.us/documents/about/pdf/2007-10-19_Rider13.pdf. Accessed: May 21, 2008.
[22] *Ibid.*
[23] Carey Cockerell, Department of Family and Protective Services, *Testimony before the Senate Committee on Health and Human Services,* (Austin, TX, April 30th 2008).

reducing workloads and caseworker turnover while improving outcomes for children and families. Reduce CPS caseloads by reducing the number of children who enter the foster care system, and continue the progress made by the APS Caseload Management Reduction Plan.

2. **Value employees:** Support an organizational culture that recognizes and appreciates high employee performance and dedicated employees' opinions. Recognize that a number of factors that contribute to job satisfaction and retention are
3. not directly related to salary and are within the employer's control. Utilize plans and strategies related to employee wellness, work/life balance and increasing employees' sense of connection with the agency.
4. **Promote employee communication and input:** Centrally gather employee information, with a focus on issues relating to workforce support and retention. Review information and seek resolution or response from the appropriate source. Work to ensure all relevant divisions are consulted when issues impact more than one division. Share information with DFPS staff using the most appropriate communication tool (e.g., DFPS Delivers, Commissioner's Q&A, Broadcast message, cascading communication).
5. **Strengthen supervision:** Better equip agency supervisors to perform their job duties and support their staff by strengthening their understanding of leadership and retention and adding "peer trainer" positions.

6. **Enhance the work environment:** Explore ways to improve employees' work environment by addressing issues related to office space, employee safety, automation needs and innovations, and flexible work schedules.
7. **Improve hiring practices:** Provide a comprehensive approach to improve hiring by identifying and/or developing policies, procedures, and best practices to help the agency locate, recruit, and hire applicants with an aptitude for direct delivery work who are capable of providing the highest level of service to DFPS clients.
8. **Region 8 Retention Pilot:** Encourage ideas and innovations supporting staff retention. Serve as a place where identified recommendations can be implemented and evaluated so that successful ideas are disseminated to the rest of the state.[24]

Department efforts focusing on the above initiatives include:

- evaluating and restructuring the hiring process;
- restructuring peer training for caseworkers;
- enhancing training for supervisors;
- using program improvement committees at a regional level to improve communication between management and frontline staff;
- evaluating the mobile caseworker pilot; and

[24] Department of Family and Protective Services, Rider 13, Human Resource Management Plan, (April 2008). Available: www.dfps.state.tx.us/documents/about/pdf/2007-10-19_Rider13.pdf. Accessed: May 27, 2008.

- implementing merit raises.[25]

Caseworker Salary and Reimbursement

Retention studies continue to list salary dissatisfaction as one of the leading causes of caseworker turnover. While the State Auditor's exit reviews do not list salary dissatisfaction as caseworkers' primary concern, the SOE reported that, of the 20 factors analyzed, salary was the greatest source of dissatisfaction among the over 5,000 employees who responded.[26] Investigative caseworkers' annual salaries start at $34,602 and those for non-investigative caseworkers start at $31,020.[27] Anecdotal evidence suggests that many caseworkers leave for other human service-related fields or educational fields. As the cost of living in urban areas across the state continues to rise, caseworkers often leave their state jobs in search of more profitable careers. Some commentators suggest that all caseworkers' salaries should be significantly increased, which would be incredibly costly to the state. Within the framework of currently available appropriations, DFPS has enacted merit pay initiatives to reward high performers.

While SB 758 required DFPS to evaluate whether education reimbursements would encourage staff retention, a number of other states have already enacted education reimbursements. While Texas and 40 other states use federal Title IV-E training dollars

[25] Department of Family and Protective Services, Rider 13, Human Resource Management Plan, (April 2008). Available: http://www.dfps.state.tx.us/documents/about/pdf/2007-10-19_Rider13.pdf. Accessed: May 27, 2008.
[26] *Ibid.*
[27] Department of Family and Protective Services, Databook for 2007. Available: http://www.dfps.state.tx.us/Documents/about/Data_Books_and_Annual_Reports/2007/databook/CPS_FY07.pdf. , Accessed: May 28, 2008.

for education stipends, other states fund additional education stipends with state appropriations. These reimbursement programs require students who study child welfare to commit to state employment for a specified amount of time. A few studies indicate that educational reimbursement program participants remain in child welfare agencies longer than non-participants.[28]

Outsourcing Case Management

Outsourcing case management services is touted as a potential solution to increase permanency and stability for foster children, and to reduce or eliminate the negative impact of high caseworker turnover on these children. According to best practices in foster care, children are more stable and reach permanency quicker when there is less caseworker turnover while the child is in substitute care. Unfortunately, because of high caseworker turnover, many children in Texas' child welfare system have multiple CVS caseworkers while in the state's care.

Last session, SB 758 required DFPS to privatize five percent of Texas' case management cases by contracting with one or more substitute care providers or child placement agencies. "Case management" includes ongoing monitoring and coordination of services needed by the child and family, caseworker-child visits, and the development and revision of the case plan. CVS caseworkers currently perform these duties.

[28] United States General Accounting Office, *Child Welfare: HHS Could Play a Greater Role in Helping Child Welfare Agencies Recruit and Retain Staff*, p.25 (2004), Available: http://www.gao.gov/new.items/d03357.pdf, Accessed: October 1, 2008.

A number of child placement agency providers advocate requiring the five percent pilot to include a continuum of case management care for the child and family from the first point of contact. This pilot would include FBSS, kinship care, and other services until the child leaves the system. Child placement agencies have a much higher caseworker retention rate, which would improve childrens' stability.

Conclusion

Reducing caseloads, retaining caseworkers, and increasing efficiencies are complex problems requiring a multi-dimensional approach. Salary increases alone will not solve the problem of employees leaving the workforce if their workload is unmanageable or if they lack adequate support from supervisors. Legislation from the past two sessions increased efficiencies by creating functional units and providing tablet PCs and mobile dictation services to caseworkers. However, DFPS should continue evaluating and implementing best practices in order to retain valuable staff. The Legislature must also continue strengthening caseworker supports in order to ensure their retention, which is vital for the stability of the child welfare system.

Statistics

AVERAGE DAILY CASELOADS

	FY 05	FY 06	FY 07
Investigation	41.1	34.7	25.3
FBSS	19.4	20.3	20.4
Conservatorship	37.1	44.5	43.3

Adapted from DFPS follow-up testimony to the Senate Committee on Health and Human Services, April 2008.

CASEWORKER TURNOVER RATES

	FY 06	FY 07	FY 08*
Investigation	34.80%	40.70%	35.40%
FBSS	25.50%	27.40%	26.80%
Conservatorship	29.80%	33.80%	21.50%

* Annualized turnover
Adapted from DFPS testimony to the Senate Committee on Health and Human Services, April 2008.

CPS WORKER TURNOVER PER REGION

	FY '06	FY '07	FY '08
Region 1	25.1%	25.9%	27.7%
Region 2	25.0%	19.2%	26.7%
Region 3	31.0%	31.1%	28.6%
Region 4	22.7%	28.4%	42.1%
Region 5	17.4%	17.0%	27.1%
Region 6	32.0%	39.5%	29.1%
Region 7	33.4%	36.2%	35.2%
Region 8	36.4%	41.0%	30.3%
Region 9	32.9%	32.0%	29.9%
Region 10	16.1%	28.5%	21.9%
Region 11	23.2%	39.2%	34.3%
Region 12	29.8%	34.1%	30.6%

Adapted from DFPS follow-up testimony to the Senate Committee on Health and Human Services, April 2008.

Recommendations

1. **Support DFPS' Rider 13 Workforce Support and Retention Initiatives.**

   Rationale: These initiatives address the needs of staff by managing workloads, valuing employees by promoting employee communication and input, strengthening supervision, improving hiring practices and enhancing their work environment. This multifaceted approach addresses many concerns that staff voiced to DFPS.

2. **Support DFPS' continued efforts to recruit from the school of social work and other human services-related degree programs.**

Rationale: Studies indicate that these degreed employees remain in the child welfare field longer than other degreed employees. Many other states impose specific degree requirements for child abuse/neglect caseworkers. Using a hiring preference rather than a mandated requirement gives DFPS the flexibility to hire quality candidates.

3. **Increase supervisor and leadership training.**

   Rationale: Enhancing supervisor training will foster better caseworker support and leadership. Caseworkers note that having a strong supervisor is one factor that determines whether they choose to continue working at DFPS.

4. **Encourage DFPS to document employees' out-of-pocket expenses.**

   Rationale: DFPS should determine if any additional money is required to cover employees' out-of-pocket expenses. Caseworkers and support staff complain that they spend out-of-pocket monies on gas, clothing for foster children and other necessities.

5. **Continue supporting the case management pilot to privatize case management services in 5% of cases.**

   Rationale: Private child placement agencies tend to have higher retention. Using child placement agency case managers could increase stability for

foster children who need the consistent presence of an adult in their lives.

Charge # 5 Foster Care

Monitor the implementation of the Department of Family and Protective Services' plan to stabilize the foster care system and increase permanency options for children. Study placement capacity to determine how Child Protective Services can better develop the necessary adoptions or foster homes to meet the needs of children and families by increasing foster care capacity, recruiting and retaining more foster and adoptive parents, increasing the use of relative care, and developing best practices for reducing foster care placement breakdowns. This includes studying innovative ways to promote adoption and kinship care in Texas and best practices for foster/adoptive parents to improve their ability to care for abused and neglected children. Explore potential improvements and enhancements in the Preparation for Adult Living (PAL) program to increase successful transitioning from foster care to adult living. Study current death review processes for children who die while in state care.

Background

Last year, over 71,000 children were confirmed victims of abuse or neglect in Texas.[1] Many of these children live in court-ordered "substitute care". The Texas Family Code defines substitute care as the placement of a child who is in the conservatorship of the department or an authorized agency in care outside the child's home. The term includes foster care, institutional care, adoption, or placement with a relative of the child.[2] In February 2008, 27,468 children lived in substitute care and of those, 17,444 lived in

[1] Department of Family and Protective Services, *2007 Databook.* p. 7, Available at http://www.dfps.state.tx.us/Documents/About/Data_Books_and_Annual_Reports/2007/databook/FY07_Databook.pdf, Accessed on: 6/2/2008.
[2] Texas Statutes, Subchapter A, Section 263.001, Family Code.

foster care.[3] These children live in substitute care until more permanent placement is determined by the Department of Family and Protective Services (DFPS) and the courts. Permanency options include returning the child to the biological parents, adoption, long term foster care, or kinship care.

When safety concerns warrant removal of a child from his/her home, Child Protective Services (CPS) prioritizes placing a child in the least restrictive environment or most home-like setting and, when appropriate, with kin.[4] CPS uses both foster homes recruited by DFPS and those recruited and managed by private child placing agencies (CPAs). In addition to placing children with kin or in foster homes, CPS may place children in residential treatment facilities or other institutions when appropriate.

Capacity Crisis

Although the rate at which children are entering the foster care system has declined over the last year, CPS struggles to find appropriate homes for some of these children. Some factors that contributed to this capacity problem include tenured foster families choosing to leave the system, an increase in the number of foster children diagnosed with complex medical and behavioral needs, and a lengthy certification process to become a foster or adoptive parent.

CPS struggles to find placements for foster children close to their homes. Children are better able to adjust if they continue attending their own school and interacting with their

[3] Carey Cockerell, Department of Family and Protective Services, *Testimony before the Senate Health and Human Services Committee*, p. 29, April 30, 2008.
[4] Department of Family and Protective Services, *Moving Foster Care Forward*, p. 3, March 2008.

peers. However, this is an unlikely scenario for many children placed in substitute care. Today, only about 38% of children living in substitute care are placed in their home counties, in part because many rural counties lack specialized providers who are able to care for high-needs children.[5] This creates difficulties not only for the children, but also for their caseworkers, guardian ad litems, and their biological parents who must travel long distances to maintain contact with them.

Last year, a number of foster children slept overnight in CPS offices because of the lack of appropriate placements. At the peak in March 2007, over 160 children across the state spent at least one night in a CPS office.[6] Many of these children were often the most high-needs children, teenagers with behavioral issues. Many children were also not new to the foster care system, but had multiple previous foster placement breakdowns.

Multiple foster placement breakdowns create instability for foster children and can affect their development, leading to behavioral and emotional problems including aggression, coping difficulties, poor home adjustment, and low self-concept.[7] Additionally, some children have had both multiple placements and multiple caseworkers. These children often have trouble making valuable connections with adults, fall behind in school, and tend to languish in long term foster care. This instability frequently leads to tragic outcomes when foster youth transition into adulthood. Many become homeless, incarcerated, or addicted to drugs.

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[5] Department of Family and Protective Services, *Follow-up to House Human Services Hearing*, March 2008.
[6] Department of Family and Protective Services, *Moving Foster Care Forward*, p. 7, March 2008.
[7] Smith, D., Stormshak, E., Chamberlain, P., and Bridges, R. Placement disruption in treatment foster care. *Journal of Emotional and Behavioral Disorders* p. 200 (2001).

Child and Family Services Review

Texas is currently involved in the second round of the Child and Family Services Review (CFSR). This review, administered by the U.S. Children's Bureau of the Administration for Children and Families, determines the quality of each state's child welfare system and ensures conformity with federal child welfare laws. The review takes place in two parts: a statewide assessment and an onsite review of child and family service outcomes and program systems.[8] Goals include safety, permanency, and child and family well being. The review also measures seven systemic factors that lead to the goals. Once the final results of the CFSR are released, states develop a program improvement plan (PIP) with the Children's Bureau to improve outcomes. Non-compliance with the approved program improvement plan can lead to monetary penalties for states.

DFPS released preliminary results during summer 2008 and has been working with stakeholders to develop the PIP. Although Texas faired well in certain aspects, the state is significantly below compliance levels in the areas of Permanency Outcome 1: children having permanency and stability in their living situation, and Well Being 1: families having enhanced capacity to provide for their children's needs. CPS was cited for placing too many children into long term foster care or "permanent managing conservatorship" and for failing to maintain regular contact with the biological parents and involve them in case plans. Although this second round of reviews occurred after the 80th legislative session, many of the concerns raised can be improved by the continued implementation

[8] Administration of Children and Families, US Department of Health an Human Services, *Child and Family Services Reviews Fact Sheet,* Available at: http://www.acf.hhs.gov/programs/cb/cwmonitoring/recruit/cfsrfactsheet.htm.

of Senate Bill 758. There will also likely be a need for future legislation to help with CFSR compliance.

Legislation

The 80th Legislature addressed the need to improve capacity and improve foster children's well-being by enacting Senate Bill 758. Part of the mandated improvement plan discussed earlier in this report included the following requirements to broaden capacity options:

- implementing an enhanced in-home support program, as enacted by Section 264.2011, Family Code, as added by this Act, with a pilot project that uses Temporary Assistance for Needy Families (TANF) funding to help offset certain poverty-related factors. Providing this assistance will help families working with DFPS in family-based safety services;
- providing additional purchased client services designed to keep families together and to reunite families more quickly while ensuring child safety. Services include mental health services and substance abuse testing and treatment;
- enhancing support of kinship placements by (1) hiring or contracting to provide additional kinship workers to provide additional support and education to relative placements and (2) purchasing additional support services for relative placements;
- expanding substitute and adoptive placement quality and capacity in local communities through the procurement of a statewide needs assessment and through the implementation of recommendations for expanding and improving provider capabilities; and

- implementing a statewide pilot program for a time-limited, post-hospitalization "step-down" rate, approved by the executive commissioner of the Health and Human Services Commission, to support the successful transition of children who have experienced or are likely to experience multiple inpatient admissions in a psychiatric hospital to an appropriate level of care.[9]

Senate Bill 758 also required that DFPS implement a new case management privatization pilot for 5% of the cases across the state. The pilot aims to improve outcomes for children by increasing continuity of care of the children and family and by funding those efforts.

Improving Outcomes for Children

Keeping Families Together

Over the last few years, the Department has moved toward implementing more family-centered policies. One of the goals outlined in Senate Bill 758 is keeping families together while ensuring children's safety. In certain cases, CPS believes it is unnecessary to remove a child from his/her home and that the family will achieve a better outcome by remaining intact. Keeping the child with the family also limits the trauma to that child. Families who remain intact are assigned to family-based safety services and work with their caseworkers to achieve certain safety goals. DFPS's Senate Bill 758 implementation plan outlines a variety of strategies to reach this family-centered goal, including: increasing the use of family group decision-making, increasing purchased client services,

[9] Texas Senate. Senate Bill 6, Enrolled Version, 79th Legislature, regular session (2005).

and beginning a new Enhanced In-Home Support pilot.[10] DFPS recently began providing Family Group Decision Making conferences during the investigation stage. These conferences bring extended family and close friends together to help support families involved in the child welfare system and to recommend safety goals. Providing these services to families up-front limits the number of children ultimately placed in foster care.

Expanding Kinship Care

Placement with kin often provides a more stable and less psychologically harmful environment than placement with strangers.[11] When a child is unable to continue living in his/her home, state and federal law requires DFPS to consider placing the child with kin prior to placement in foster care. Texas law defines kin as either a relative or a person who has a close familial relationship. As of February 2008, 8,445 DFPS children were in kinship care.[12]

Financial resource limits are often cited as one of the reasons why kin are unable to care for a child. Financial assistance to kinship care providers comes either through Temporary Assistance to Needy Families (TANF) grants, if the care provider is related to the child by blood or marriage and is eligible, or through general revenue allocation. This assistance can include a one-time payment of $1,000 per family, up to $500 per child per year, and day care assistance depending on available appropriations. Federal

[10] Department of Family and Protective Services, *SB 758 Implementation Plan*, p. 5, December 2007.
[11] Gleeson, J., and Craig, L. Kinship care in child welfare: An analysis of states' policies. *Children and Youth Services Review* (1994).
[12] Carey Cockerell, Department of Family and Protective Services, *Testimony before the Senate Committee on Health and Human Services*, p. 29, April 30, 2008.

law prevents states from paying kin the full foster care rates unless they are certified or licensed as a foster parent. The immediacy of a kin placement often prevents them from meeting the necessary requirements to become certified foster parents. Some kinship placements are designed to be temporary, with the ultimate permanency plan for the child being reunification with the biological parents. In those cases, it is impractical for kin to become certified foster parents. When long term kinship care is needed, the Department can partner with relatives to help them become verified foster parents.

The Department continuously strives to identify family relatives who are able to provide care for children even after they have been placed in foster care. Parents might not identify available kin at the onset of removal and, in some cases, a non-custodial parent maybe be unaware of his or her child's involvement with CPS. As the Department expands the use of Family Group Decision Making conferencing and Family Team Meetings, parents' ability to identify potential kinship caregivers increases. It is important for the Department to remain vigilant in identifying such placement possibilities in order to prevent long term foster care.

Addressing Concerns of Foster and Adoptive Families

To better understand why Texas has a capacity crisis, it is important to examine why tenured foster families are leaving the child welfare system. As stated earlier in this report, monumental changes in child welfare occurred in the past two sessions. Legislators have pushed for more accountability and quality controls after hearing reports about child maltreatment within the foster care system. New laws and new minimum standards regulating residential child care were enacted. Although many foster parents

supported the push for more accountability, many also voiced concerns that their needs were not addressed in the recent reforms. As a result, a perceived lack of support from policy makers and DFPS has led some tenured foster parents to leave the child welfare system.

Foster parents cite the implementation of new minimum standards as one of their primary concerns. The Department recently overhauled the 24-hour residential care minimum standards for the first time in over a decade. These rules are now weighted based on the level of safety risk a deficiency presents to children. Full implementation of the weighted rules should occur in Fall 2008. DFPS held multiple focus groups and public hearings to assist in the development of these standards. Unfortunately, some foster parents and certain CPA providers believe their concerns about the new standards were not addressed and that implementation of these standards increases costs. Although the 80th Legislature increased foster care rates, many believe the rates still need to be raised in order to pay for the enhanced requirements mandated by the minimum standards. Some foster parents and CPA providers have also expressed concerned that, as the standards and monitoring have increased, the partnerships between DFPS, CPAs and foster families have decreased. In their view, they are rarely rewarded for fostering positive outcomes in the children. Additionally, they have expressed frustration over not being consulted about how their children can be helped in the transition back to living with their biological families.

Senate Bill 758 created a licensing committee within DFPS to review licensure violations and trends. The committee, comprised of both public and private members, was created to review the effectiveness of the new standards and operate as an outlet for CPA providers and foster parents to voice their concerns. Some have noted that the SB 758-required case management privatization pilot would foster better coordination of care for the children by allowing a CPA to work with the biological family, kinship care provider, and foster family. The Department and the legislature should develop better policies that reward foster families and CPA providers for their contributions that lead to positive outcomes for these children.

Additionally, both foster parents and CPA providers recommend better assessments for children as they enter the foster care system. The law requires that each child must receive an assessment, which may be accomplished by a caseworker within thirty days of entering the system. Under the new Star Health the managed care system for foster children which was implemented in April 2008, medical assessments are performed within thirty days. These assessments can include assessing a child's behavioral health needs upon CPS' request. Longitudinal data will be necessary to determine whether this assessment is adequate. Poor assessments can lead to behavioral crises and foster home breakdowns.

Although potential foster and adoptive families have a minimum thirty-five hours of Parent Resource for Information, Development, Education (PRIDE) training, many feel unable to fully comprehend and manage the emotional needs of the children. Many foster children suffer from Reactive Detachment Disorder or Post Traumatic Stress

Disorder, which often lead to behavioral outbursts that can strain families and potentially cause placement breakdowns. The Department and child placing agencies should consider ways to better prepare families to manage the emotional needs of their children. Innovative training practices, such as Trust-Based Relational Intervention, developed by the Institute of Child Development at Texas Christian University, are available. These training practices specifically train families to better understand and care for these children. The new Star Health program should also help support foster families that have children with these disorders.

Recruitment of Foster and Adoptive Parents

DFPS and private CPAs both play a role in recruiting foster and adoptive parents. DFPS also outlines strategies to build capacity in its *Moving Foster Care Forward Plan*. Their efforts include developing a Statewide Placement Quality and Capacity Needs Analysis.[13] This needs analysis will provide the foundation for developing a strategic plan that will result in the expansion and improvement of substitute care and adoptive placement quality and capacity in local communities.[14]

The CPA provider community plays an integral role in achieving timely permanency for these children. CPAs recruit and manage about 80% of the foster families in the child welfare system, but are only contracted to provide approximately 40-50% of the adoptions. They have long voiced their desire for DFPS to increase contracted adoption

[13] Department of Family and Protective Services, Moving Foster Care Forward, March 2008, Available at: http://www.dfps.state.tx.us/documents/about/pdf/2008-03-27_foster_capacity.pdf, p. 8, Accessed on: June 16, 2008.
[14] *Ibid.*

services which would enable them to continue building adoption capacity. In addition to partnering with CPAs, DFPS has its own recruitment division, termed the Foster Adopt Division (FAD).

Partnering with local communities is key to the recruitment efforts of foster and adoptive families and the ability for DFPS to build capacity. Some community outreach campaigns include the use of websites such as the Texas Adoption Resource Exchange (TARE); Heart Galleries, which consist of photo exhibits of older children who are ready for adoption; and television, radio and print ad campaigns. Both private child placing agencies and DFPS have recognized the importance of partnering with faith-based communities and have tried to target this community for recruitment of foster and adoptive families.

Improving Outcomes for Youth in Transition

Each year over 1,300 Texas children age-out of foster care.[15] The Department offers a variety of programs that help them transition into independent living. These include:

- **Preparation for Adult Living (PAL) programs**: Life-skills training for youth starting at age 16 to help with the transition. Training must include personal and interpersonal skills, job skills, housing, transportation, health, planning for the future and money management;[16]
- **Education and Training Voucher (ETV) Program and tuition fee waiver**: The tuition fee waiver provides free tuition to state supported colleges,

[15] Department of Family and Protective Services, *Transition Center Guide*, May 2007.
[16] Department of Family and Protective Services, Transition Living Services, Available at: http://www.dfps.state.tx.us/Child_Protection/Transitional_Living/default.asp, Accessed on: June 16, 2008.

universities, and vocational schools in Texas and helps with supports services. The ETV provides up to $5,000 for foster youth through federal grants to supplement support services, including housing, books, child care and some transportation;

- **Circles of Support (COS):** A youth-driven Family Group Conference, where identified caring adults help with the youth's transition plan. These adults often include biological family members, CASA volunteers, teachers or other caring adults;
- **Transition centers:** These centers offer a centralized approach to providing assistance for youth with health care, employment assistance, life skills training, transitional living arrangements, continuing education, and mentor programs. Currently, the state has eight transition centers with three more coming online in the next few years;[17]
- **Extended Foster Care:** Youth up to the age of 22 may stay in care while trying to complete high school or up to age 21 to complete vocational training. Youth may also return to care after they have aged-out if they wish to return to high school or obtain their GED;
- **Transitional Medicaid:** Youth continue to be eligible for Medicaid from 18 to 21 years of age with a single application;
- **Youth Leadership and Development:** The Department provides youth leadership and development activities including regional and statewide teen conferences and regional and statewide youth leadership councils; and

[17] Department of Family and Protective Services, Hearing follow-up to the Senate Committee on Health and Human Services. April 30, 2008.

- **Texas Youth Hotline:** The hotline is a resource for youth under 21 years of age, including those who have aged out of the foster care system. This hotline provides crisis counseling and information and referrals.

Housing and job availability often top the list of foster care alumni's concerns. According to studies conducted by Casey Family Programs, one-third of foster care alumni have incomes below the poverty level and more than one in five experience homelessness once they leave care.[18] Although many programs aim to support foster youth as they age out, they often have trouble transitioning into independent living. Many struggle with mental health issues and are often unable or unwilling to complete their high school degree. Once emancipated, many choose to cut off all DFPS support. Having at least one lifelong connection with a caring adult, perhaps a teacher, family member, or caseworker, can improve outcomes for foster youth. A caring adult can provide emotional support; guidance on employment, education, and relationship issues; and assistance in times of emergency. Transition centers also show great success in helping foster care alumni. However, a lack of transportation or available centers in some counties limits accessing them.

Conclusion

The capacity crisis and caseworker and foster parent retention issues affect the outcomes in foster children. If CPS is unable to find an appropriate placement for a child, the child may cycle through multiple foster families and caseworkers and, if not adopted, will

[18] Casey Family Programs, *2020: A Vision for America's Children,* 2007.

likely struggle to become a successful adult. Texas must do a better job to build capacity and retain tenured foster parents and caseworkers.

Recommendations

1. **Require the DFPS licensing committee to hold public hearings twice a year regarding the 24-hour residential minimum standards to allow foster parents to testify. Additionally, require the committee to review standards that might negatively affect foster parents. Report findings to the legislature and DFPS.**

   Rationale: Some foster parents feel that they have no opportunity to voice concerns about the minimum standards. The licensing committee established in SB 758 provides such a forum.

2. **Create a mentoring pilot for foster parents to mentor biological families.**

   Rationale: Many foster families have expressed a desire to work with biological families on their parenting skills in order to ease the transition of children back into their biological families' care.

3. **Support and fund more Court Appointed Special Advocates (CASA) volunteers.**

   Rationale: Courts appoint CASA volunteers to serve as advocates for the best interests of the children to whom they are appointed in a court proceeding. Currently, CASA serves about half of the children

involved in Texas' child welfare system. Studies show that when a CASA volunteer is appointed, children reach permanency more quickly.

4. **Encourage DFPS and child placing agencies to train foster and adoptive parents in Trust-Based Relational Intervention.**

   Rationale: Many foster children suffer from clinical psychological disorders. This intervention shows marked results in helping parents cope with their troubled children. Using this or a similar intervention will likely help decrease the number of foster and adoptive placement breakdowns.

5. **Require five day notification to providers for non-emergency changes in placement of foster children.**

   Rationale: Child placing agencies, foster families and foster children need time to prepare for a placement change (move) whether a child returns to his/her biological family or moves into another foster placement. This notification will help prevent unnecessarily traumatic disruptions.

6. **Encourage co-location of CPS licensing staff and conservatorship caseworkers at child placing agency offices.**

   Rationale: This would foster better partnerships between CPS and child placing agencies.

7. **Fund the cost of care.**

   Rationale: According to providers and foster parents, the new minimum licensing standards have increased the cost of caring for children. Funding the cost of care would greatly assist in retaining child placing agency providers and foster parents.

8. **Direct HHSC and DFPS to study and implement a new rate model that focuses on outcomes and phases out the current Level of Care rate plan.**

   Rationale: The current rate plan unfairly penalizes providers and foster parents for good outcomes by lowering the level of care when a child shows signs of improvement. Developing a rate model that pays for performance encourages the use of best practices and ultimately will produce a better system of care.

9. **Implement an official "exit" survey for foster parents who choose to leave the system.**

   Rationale: This would create a tracking mechanism to identify the reasons why foster parents decided to stop fostering and will assist in developing policies that encourage tenure.

10. **Direct DFPS to examine the re-verification process for foster and adoptive parents in order to streamline the process.**

Rationale: Some foster and adoptive parents expressed concern that the re-verification process is cumbersome. By streamlining this process and making it more user-friendly, more foster and adoptive parents will likely continue caring for children.

11. Support the use of transition centers and increase the number of transition centers.

Rationale: This would help more foster youth successfully transition out of substitute care. These centers assist foster youth with job training, enrolling in college, managing a budget and housing needs, connecting with the community and planning for their futures.

12. Require Preparation for Adult Living (PAL) classes to emphasize community resources, including food stamps, low income housing and job opportunities in high needs areas.

Rationale: Emphasizing community resources will better prepare foster youth for adult life.

13. Encourage co-location of various state agencies (e.g., HHSC, DSHS, TWC) at transition centers to help youth who age out of care.

Rationale: Foster youth have limited means of transportation and creating a one-stop-shop for support services can ease that burden.

14. Continue to support the case management pilot and increase the pilot to 10%, including family-based safety services and kinship care programs.

Rationale: Limited appropriations for this measure prevented the agency from moving forward with this pilot. However, Texas continues to need a better system of care for children in foster care. This pilot presents an opportunity to implement and study innovative privatization practices used in other states

Charge # 6 Child Abuse Prevention

Examine Texas' current strategies for preventing child abuse. Specifically study the effectiveness of current programs and how these programs compare to other state efforts. Identify national research-based solutions, including best practices and programs addressing sexual abuse. Explore promising existing and emerging approaches to child abuse and neglect prevention, especially those with a strong evidence base. Identify additional funding sources for increased child abuse prevention activities by the state.

Background

Over 71,000 children were confirmed victims of child abuse and neglect in Texas last year. Nationally, child abuse and neglect costs $103.8 billion dollars annually in direct and indirect costs.[1] Texas spends roughly 2.5 billion dollars per biennium on the Department of Family and Protective Services (DFPS) and the protection of children and vulnerable adults and, of that amount, Texas spends roughly $35.5 million towards prevention of child maltreatment each year.[2]

Federal, state, and local dollars have consistently funded the "back end" of the system, paying for foster care rather than addressing prevention. Child maltreatment can lead to future criminal activity and mental and physical health problems, which increases both monetary and ethical costs to society. This epidemic cannot be solved without a

[1] Prevent Child Abuse America, *Economic Impact Study*, September 2007, Available at: http://www.preventchildabuse.org/about_us/media_releases/pcaa_pew_economic_impact_study_final.pdf, Accessed on: 6/28/2007.
[2] Interagency Coordinating Council on Building Healthy Families, *An Inventory of State-Funded Child Abuse and Neglect Prevention and Early Intervention Programs,* June 2006.

coordinated prevention effort between the state, communities, and families. However, as the stewards of taxpayers' dollars, and given the finite amount of available appropriations, the legislature has an obligation to scrutinize funded prevention programs to determine whether they are successful.

The term "prevention" is typically used to represent activities that stop an action or behavior. It can also be used to represent activities that promote a positive action or behavior. Research has found that successful child abuse interventions must both reduce risk factors and promote protective factors to ensure the well-being of children and families.[3]

Prevention programs consist of three levels of services: *primary* [prevention programs], which are directed at the general population; *secondary* [prevention programs], which target high-risk individuals or families in which maltreatment is more likely to occur; and *tertiary* [prevention programs], which focus on families in which abuse has already occurred.[4] Primary prevention programs consist of public service announcements and public awareness campaigns regarding child abuse. Secondary programs include home visitation programs, respite care, and targeted parent education programs. Examples of tertiary programs include family-based safety services, mentoring, and mental health programs. In order to maximize outreach, Texas and local communities must cover all levels of prevention services.

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[3] Child Welfare Information Gateway, *Overview Prevention of Child Abuse and Neglect*, Available at: http://www.childwelfare.gov/prevention. Accessed on: 6/28/2008.
[4] Thomas, Leicht, Hughes, Madigan, Dowell, *Emerging Practices in the Prevention of Child Abuse and Neglect,* p. 8, (2003) Available at: http://www.childwelfare.gov/preventing/programs/whatworks/report/emerginga.cfm, Accessed on: 6/29/2008.

Prevention Strategies

Prevention programs typically utilize many of the following strategies: home visitation, parent education, child education, public awareness campaigns, respite and crisis care, and family resource centers.[5] In general, national research on effective prevention programs typically concentrates studies on only three of these strategies: home visitation, parent education, and school-based child sexual abuse prevention. Following the research trends, policy makers across the nation have targeted their funding to evidence-based programs and programs that use evidence-based practices. The terms evidence-based practice and programs have different meanings in different areas of study. In terms of child welfare and prevention, evidence-based programs show strong research design, evidence of significant positive effects, sustained effects, and capacity for replication.[6] Programs that use evidence-based practices incorporate elements that have been proven effective but are often not implemented exactly as the initial evidence-based program model.

Home Visitation Strategies

These programs provide in-home visitation to parents and their children by trained professionals such as social workers and nurses. Home visitation programs guide parents by teaching life skills, providing social supports, and linking them to social services. The Centers for Disease Control recommends using home visitation programs to decrease the

[5] Thomas, Leicht, Hughes, Madigan, Dowell, *Emerging Practices in the Prevention of Child Abuse and Neglect,* (2003) Available at: http://www.childwelfare.gov/preventing/programs/whatworks/report/emerginga.cfm, p. 9-10, Accessed on: 6/29/2008.

[6] The Child Welfare Information Gateway, About Evidence Based Practice, Available at: http://www.childwelfare.gov/systemwide/service/improving_practices/about.cfm, Accessed on: 7/1/2008.

occurrence of child maltreatment. Evidence shows that these programs are successful at preventing child abuse and neglect.[7]

On the other hand, not all home visitation programs are equally successful. Programs that use mental health professionals and nurses have better outcomes than programs that use paraprofessionals.[8] Researchers report that nurses tend to concentrate their outreach on issues of personal health and parenting, whereas paraprofessionals emphasize environmental health and safety, social supports, and the mother's life-course development.[9] Higher education levels attained by home visitation caseworkers often equate to a higher implementation cost. This factor leads budgeters to contemplate the cost-benefits of using programs that employ nurses versus programs using paraprofessionals. Programs that have been evaluated and proven effective include the Nurse-Family Partnership, Healthy Families America, and STEEP.

Parent Education Strategies

Parent education strategies focus on teaching parents to change behaviors associated with child abuse and neglect. Similar to home visitation programs, these strategies address positive discipline techniques, child development, positive play techniques, and accessing social services.[10] Parent education programs often use peer-to-peer leadership and mentoring to accomplish the education goals. Although a few studies of parent education

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[7] The Centers for Disease Control's Task Force on Community Preventive Services, *Recommendations to Reduce Violence Through Early Childhood Home Visitation, Therapeutic Foster Care, and Firearms Laws,* Available at: http://www.thecommunityguide.org/violence/viol-AJPM-recs.pdf, p. 2, Accessed on: June 2008.
[8] *Ibid.*
[9] The Promising Practice Network, *Programs that Work: Nurse Family Partnership*, Available at: http://www.promisingpractices.net/program.asp?programid=16, Accessed on: June 2008.
[10] *Ibid.*

programs have shown success, more research is needed. Some effective programs include Parents as Teachers, Circle of Parents, and Parents Anonymous.

Child Sexual Abuse Prevention Strategies

Child sexual abuse prevention programs differ significantly from other prevention programs in that they target the potential victim and attempt to raise parental awareness.[11] Often these programs are taught in school and focus on changing children's behavior. Two techniques taught to children are how to distinguish appropriate touching from inappropriate touching and how to protect themselves. Other programs teach parents how to detect sexual abuse and how to restrict access of potential predators. Proven programs in this arena include Project Trust, Good Touch/Bad Touch, and Safe Child.

Research on What Works

Federal and state governments employ multiple methods to determine the effectiveness of a program. Some rely on university research to evaluate programs, while others rely on private evaluations. As governments push for more accountability, many prevention programs are financing their own research studies to justify state funding.

According to the Child Abuse Information Gateway, prevention programs are more effective with parental involvement throughout the planning and implementation process and when the programs use evidence-based practice.[12] Studies have also revealed that

[11] National Conference of State Legislatures, Testimony before the Texas Senate Committee on Health and Human Services, p. 9, April 2008.
[12] The Child Abuse Information Gateway, Preventing Child Abuse and Neglect Factsheet, Available at: http://www.childwelfare.gov/pubs/factsheets/preventingcan.cfm, Accessed on: 7/2/2008

instead of focusing only on decreasing risk, many effective programs teach parents protective factors such as nurturing, attachment, and child development.[13]

In 2003, the Office on Child Abuse and Neglect at the federal Children's Bureau published the study *Emerging Practices in the Prevention of Child Abuse and Neglect,* an evaluation of the effectiveness of prevention programs from around the country.[14] Other noteworthy evaluation programs include the Blueprints for Violence Prevention and the Promising Practices Network. Started by the University of Colorado and supported by the Office of Juvenile Justice and Delinquency Prevention, Blueprints for Violence Prevention reviews violence prevention programs to determine effectiveness. This initiative employs strict scientific standards to develop a list of both model programs and promising programs. Blueprints also partners with prevention providers from around the country to help replicate these model programs. The Promising Practices Network, operated by the Rand Cooperation, seeks to provide policy makers with an impartial list of prevention programs that have been scientifically screened and labeled as a proven or promising program. Similar to the Blueprints model, programs are evaluated and listed on their web site.

Other Innovative Practices

Besides focusing attention on funding individual evidence-based prevention programs, some states, including Texas, are moving toward providing "wrap-around" services for

[13] The Child Abuse Information Gateway, Preventing Child Abuse and Neglect Factsheet, Available at: http://www.childwelfare.gov/pubs/factsheets/preventingcan.cfm, Accessed on: 7/2/2008
[14] Thomas, Leicht, Hughes, Madigan, Dowell, *Emerging Practices in the Prevention of Child Abuse and Neglect* (2003) Available at: http://www.childwelfare.gov/preventing/programs/whatworks/report/emerginga.cfm, Accessed on: 6/29/2008.

at-risk families using a system-of-care model. Such programs coordinate service plans and blend funding from multiple systems to address the individualized needs of a family. Often families need multiple support services involving more than one service agency. Such services may include substance abuse, mental health, judicial system, early childhood care, and juvenile justice assistance.[15] Service agencies work in tandem with families to create a coordinated service plan. By addressing the multiple needs of a family, the systems-of-care models decrease the risk of future child abuse and neglect. The Substance Abuse and Mental Health Services Administration (SAMHA) supports systems-of-care models through funding grants, training and outreach.[16] Although SAMHA has partnered with certain Texas counties including Travis, Tarrant, El Paso, and Harris, many communities struggle with developing a system of care model. Problems arise because the funding is siloed, and there is a lack of shared accountability between systems and a lack of a clear mandate for development.[17]

According to Casey Family Programs, three states that have passed successful wrap-around services legislation are California, Washington, and Nevada. Programs in these states provide intensive mental health services to children and their families.

Other innovative state programs include:

- **Maryland Opportunity Compact -** This prevention and early intervention project was developed as part of the More for Maryland Campaign, which is a

[15] Carolyne Rodriguez, Casey Family Programs, *Testimony Before the Senate Committee of Health and Human Services,* April 2008.
[16] *Ibid.*
[17] *Ibid.*

contract between the state, businesses, and citizens to create more opportunity, more accountability, and more effective use of tax dollars. The Compact aims to provide a good start for all children, strengthen vulnerable families, and make government more efficient and accountable. The private sector invests seed capital in proven strategies. These investments reduce the need for foster care and ultimately help save the state money. As the savings grow, a portion is reinvested in maintaining proven programs, further expanding prevention efforts;[18] and

- **Georgia Family Connection Partnership -** This initiative improves outcomes for at-risk children by using a statewide network of public and private agencies. This partnership provides training, enhances public awareness, and promotes best-practices that have been proven in communities.[19]

Texas Strategies

Recent Texas Legislative Action

Recognizing the increased importance of prevention programs, the Legislature enacted a number of bills that direct a coordinated and careful approach for prevention and early intervention of child maltreatment. House Bill 1685, passed by the 79th Legislature, established the Interagency Coordinating Council for Building Healthy Families. The Council is required to recommend strategies that improve the coordination and collaboration of child abuse and neglect prevention and early intervention programs in the eleven state agencies appointed to it.[20] The Council took an inventory of all

[18] Nina Mbengue, National Conference of State Legislatures, *Testimony Before the Senate Committee on Health and Human Services*, p. 15, April 30, 2008.
[19] *Ibid.*
[20] Texas House, House Bill 662, Enrolled Version, 80th Regular Session, (2007).

prevention programs receiving state funding and recommended continued state funding for prevention. The Council also recommended that the state implement an evaluation of the various programs around the state to determine their effectiveness. Senate Bill 6, from the same session, required DFPS to fund evidence-based prevention programs that target child abuse and neglect and to prioritize programs that target children whose race or ethnicity is disproportionately represented in the child protective services system.[21]

House Bill 662, from the 80th Legislature (2007) required the continuation of the Interagency Council on Building Healthy Families and tasked the Council with developing a long-range strategic plan for child abuse and neglect services. Specifically, the strategic plan must provide strategies that:

- reduce the need for services (foster care) addressing child maltreatment;
- transition to a system that promotes child abuse and neglect prevention services and prevents the need for foster care, thereby creating cost savings that can lead to increase prevention services funding in the future; and
- provide detailed recommendations for child abuse and neglect public awareness efforts and outreach.[22]

The bill also charged the Council with evaluating and making recommendations regarding the effectiveness and efficiency of existing programs, the potential for streamlined funding mechanisms, methods of improving the delivery of services, and the need for a potential increase in state funds to ensure effective investment. The Council

[21] Texas Senate, Senate Bill 6, Enrolled Version, 79th Regular Session, (2007).
[22] Texas House, House Bill 662, Enrolled Version, 80th Regular Session, (2007).

was finalizing its strategic plan at the time of the release of this report. The draft strategic plan noted that it will provide policy makers with a foundation for more comprehensive planning to prevent child abuse and neglect in the future.[23] The Office of Community Projects, Graduate College of Social Work, at the University of Houston will conduct the evaluation of Texas' prevention programs and report to the Legislature their findings by December 2009. The study will only evaluate programs that directly address child maltreatment, thereby excluding many prevention programs that target juvenile delinquency. The work of the ICC is intended to lead to better coordination between state agencies and local community-based organizations that will, in turn, reduce the need for foster care and related support services. Many of the family-focused initiatives mandated in Senate Bill 758 (80th Legislature) can also be seen as tertiary prevention efforts. The use of family-based safety services and strengthening families initiatives are intended to prevent future child abuse and neglect among families that have already been identified.

State funding for most of the child abuse and neglect prevention programs can be found in agency's budget. These appropriations are located in Strategies A2.12- A2.17 of the DFPS budget.[24] Child maltreatment prevention dollars are intertwined with drop-out prevention and juvenile delinquency prevention because many of these programs target the same at-risk children and indirectly affect child maltreatment outcomes by reducing

[23] Interagency Coordinating Council on Building Healthy Families, Draft Strategic Plan, Available at: http://www.dfps.state.tx.us/documents/Prevention_and_Early_Intervention/pdf/2008-06-09_plan.pdf p. 2, Accessed on: June 2008.
[24] Texas House, House Bill 1, Enrolled Version, 80th Regular Session, (2007).

risk factors. The majority of funding for these programs comes from the federal government.

The Division of Prevention and Early Intervention

DFPS manages the distribution of appropriations and contracts with community-based programs that address child maltreatment and juvenile delinquency in the Division of Prevention and Early Intervention (PEI). Although the appropriations bill mandates funding to a few individual programs, PEI competitively procures many of the prevention programs that are funded through the state. Programs can be classified under the following strategies:

- **Services to At Risk Youth (STAR):** Includes family crisis intervention counseling, short-term respite care, and individual and family counseling. STAR programs are available in all 254 counties in Texas and address both child maltreatment and juvenile delinquency;
- **Texas Youth and Runaway Hotlines:** Provides twenty-four hour crisis intervention and telephone counseling for youth. The hotline also helps clients by giving them referrals for food, shelter, transportation, and message relays between runaways and parents;
- **Texas Families: Together and Safe:** Provides evidenced-based services that promote parental education and positive behaviors;
- **Family Strengthening Program:** Provides evidence-based services to increase family protective factors and resiliency;

- **Community-Based Child Abuse Prevention:** Increases awareness of existing prevention services; strengthens community and parental involvement in child maltreatment efforts;
- **Tertiary Child Abuse Prevention:** Provides prevention and intervention for children who have been identified by CPS as having been or are at risk of being abused or neglected;
- **Community Youth Development:** Targets certain at-risk communities with high incidence of juvenile crime and provides mentoring, youth employment programs, career preparation, and alternative recreational activities; and
- **Youth Resiliency Program:** Community collaborative program that uses evidence-based services to increase youth resiliency while preventing juvenile delinquency.[25]

In light of the legislature's preference for funding evidence-based programs and programs that use evidence-based practices, PEI developed a continuum of evidence-based practices in their Requests for Proposals. This model was developed in conjunction with the Children's Bureau and ranks programs as:

Level I - Emerging and Evidence Informed Programs and Practices: Programs or practices which have a strong theoretical foundation and are considered generally accepted practice for preventing juvenile delinquency. Programs and practices may have been evaluated using less rigorous evaluation designs (e.g. pre- and post-tests,

[25] Carey Cockerell, Department of Family and Protective Services, *Testimony before the Senate Committee on Health and Human Services*, pages 42-50, April 30, 2008.

no use of comparison groups) or an evaluation may be in process with results not yet available;

Level II - Promising Programs and Practices: Programs or activities which have had at least one study using some type of control or comparison group and were found to be effective in promoting positive outcomes for youth and preventing juvenile delinquency;

Level III - Supported and Efficacious: Program or practice that has had at least two rigorous randomized control trials (or other comparable methodology) which found it to be effective. The program or practice has not been replicated in multiple sites; and

Level IV- Well-Supported and Effective: Program or practice that has had at least two rigorous randomized control trials (or other comparable methodology) which found it to be effective. The program or practice has been replicated in multiple sites.[26]

PEI monitors prevention contracts by assessing whether the programs meet certain performance measures. Contract monitoring is based on an annual risk assessment and is conducted through either on-site visits or desk review of documents and information. PEI conducts programmatic reviews and fiscal reviews depending on their assessment of the contractor's performance.[27]

[26] Department of Family and Protective Services, Hearing follow-up from April 30th Senate Committee on Health and Human Services, 2008.
[27] Carey Cockerell, Department of Family and Protective Services, *Testimony before House Human Services*, p. 12, April 30, 2008.

Indirect Services That Provide Prevention

This report focuses mainly on prevention programs that directly affect child maltreatment. However, there are multiple programs within the state that indirectly contribute to decreasing the incidence of child maltreatment. When a family is able to receive social services such as substance abuse treatment, mental health care, Temporary Assistance to Needy Families (TANF), Medicaid, Food Stamps, and family violence counseling, the risk factors associated with child maltreatment and/or increase protective factors are decreased. To view a more thorough list of indirect services available from the state see The Interagency Coordinating Council on Building Healthy Families Inventory Report.[28]

Funding for Prevention

As stated earlier in the report, most of the funding for Texas' prevention programs is provided via pass-through dollars from the federal government: TANF and Title IV-B Part II: Promoting Safe and Stable Families. The federal government mandates one funding stream, Community Based Child Abuse, although the state has flexibility in the details of program implementation.[29] Other sources of funding include state General Revenue and the Child Abuse Trust Fund. According to the National Conference of State Legislatures, additional funding sources include Social Security Block Grants, Title XIX Medicaid, Centers for Disease Control, Maternal Child Health Bureau, U.S. Department

[28] Interagency Coordinating Council on Building Healthy Families, *An Inventory of State-Funded Child Abuse and Neglect Prevention and Early Intervention Programs,* p. 20*,* June 2006.
[29] *Ibid*.

of Justice, special license plates, and birth certificate fees.[30] Foundations and non-profit organizations play an important role in funding prevention programs. Without their assistance, many programs would cease to operate. County governments similarly play a key role in funding programs in their respective communities. Successful programs pool funding from a variety of sources. Sustained funding for the prevention of child maltreatment can only occur through continued partnerships between federal, state, local governments and private community organizations.

Conclusion

Successful state child maltreatment prevention plans utilize a continuum of care using evidence-based practices. Texas must continue to not only support primary, secondary, and tertiary prevention services but also indirect services that provide stability for families. Private and public partnerships are essential to truly address the needs of families and to ultimately decrease child maltreatment. Policy makers should use guides such as Blueprints for Violence Prevention and Promoting Practices Network when deciding on which programs to promote in Texas. The work of the Interagency Coordinating Council of Building Healthy Families will provide policy makers with a strategic plan and a research-based evaluation of Texas' prevention programs that will help legislators build a successful prevention model for Texas.

[30] Nina Mbengue, National Conference of State Legislatures, *Testimony before the Senate Committee on Health and Human Services*, p. 11, April 30, 2008.

Recommendations

1. **Continue supporting early childhood home visitation programs.**

   Rationale: Many of these programs have been proven effective in preventing child abuse and neglect.

2. **Invest in evidence based, research based, or promising practices.**

   Rationale: These practices would enable maximization of the rate of return for the limited appropriations available for prevention programs.

3. **Require DFPS to develop a prevention plan that ensures a prevention continuum across various regions, and fund programs across the continuum.**

   Rationale: This approach ensures that proven prevention programs are available for children at different ages and stages in their lives.

4. **Encourage cross-system collaborations by funding wrap-around services.**

   Rationale: Comprehensive approaches to service provision help strengthen families and ensure that their needs are addressed, which will help prevent children from being required to enter into foster care.

Charge #7: Wellness

Study the changes in statute contained in SB 10, 80th Legislature, as well as the state's current prevention and wellness efforts and chronic care management efforts, and identify opportunities for improvement in state policies and programs. Examine options for expanding and optimizing the state's current investment in wellness programs and management tools for individuals with chronic care conditions, including options that address childhood asthma. Review partnerships with the private sector that specifically address the following:

- *tobacco cessation, including the evaluation of a statewide smoking ban in public places;*
- *reducing obesity;*
- *availability and effectiveness of childhood and adult vaccines, including public education programs to promote the use of vaccines; and*
- *more effective management of chronic care conditions.*

Background

Seven of every ten American deaths are the result of chronic, preventable conditions such as heart disease, stroke, cancer, or diabetes.[1] Although genetics and other factors contribute to the development of chronic diseases, major contributors stem from personal choices such as tobacco use, poor nutrition, and physical inactivity. Of the $1.4 trillion spent in the U.S. on health care each year, 75 percent is spent on treating preventable

[1] The Centers for Disease Control and Prevention, *Chronic Diseases: The Leading Causes of Death in Texas*, 2007, p. 1.

chronic conditions.[2] A 2008 study found that an investment of $10 per person per year in proven community-based programs to increase physical activity, improve nutrition, and prevent tobacco use could save the country over $16 billion annually, a return of $5.60 for every $1 invested.[3] The report estimates that, in Texas, investing $10 per person per year would yield $1 billion in savings within five years of implementing strategic disease prevention programs in communities, a return of $4.70 for every $1 spent.[4] The leading cause of death in Texas is heart disease, which accounts for 28 percent of all deaths annually, followed by cancer and stroke. While screenings are generally the most effective in detecting the presence of cancer in a patients and have been successful in reducing the prevalence of cancer in the state, the major risk factors for heart disease and stroke continue to grow in prevalence, including smoking and being overweight.[5]

Chronic Care Management

Chronic Care Legislation

In recent years, Texas lawmakers have passed legislation intended to better manage chronic conditions and promote the prevention of these diseases, mostly among Medicaid populations, in order to improve care and reduce long-term health care costs to the state. In 1997, the 75th Legislature took a step in this direction by passing Senate Bill 162, which directed the Health and Human Services Commission (HHSC) and the Texas

[2] National Conference of State Legislators, Critical Health Areas Program, *Chronic Care and Quality*, accessed March 27, 2008.
[3] Trust for America's Health, *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities,* July 2008, p. 1.
[4] *Ibid*, p. 33.
[5] The Centers for Disease Control and Prevention, *Chronic Diseases: The Leading Causes of Death*, 2007, p. 1.

Diabetes Council to develop a Texas Medicaid Diabetes Care pilot program.[6] The 77th Legislature passed Senate Bill 283, requiring HHSC to ensure that contracted managed care organizations (MCOs) develop and implement disease management programs to address chronic health conditions, including asthma and diabetes.[7] The bill also required HHSC to assess the benefits and costs of applying disease management principles in the delivery of Medicaid managed care. The 79th Legislature also made a chronic kidney disease management program available to Medicaid recipients. The 78th Legislature passed House Bill 727, which created the Medicaid Enhanced Care Program and expanded the availability of chronic disease managed services under Medicaid to recipients not covered by managed care plans.[8] Previously, Medicaid recipients suffering from chronic conditions who were ineligible for managed care coverage and were instead classified as fee-for-service or Primary Care Case Management (PCCM) recipients had no state-funded resource for disease management services. The program also introduced a 24-hour nurse advice line staffed with community-based Registered Nurses available to give callers advice and information on chronic disease management.

The 79th Legislature passed House Bill 1771, which established an Integrated Care Management (ICM) model pilot program for Medicaid clients who are eligible for both Medicare and Medicaid, receive cash and non-cash assistance, and are served under a Community Based Alternatives (CBA) Medicaid waiver.[9] Under this pilot program, recipients meeting the above description are assigned a Primary Care Physician (PCP) to

[6] Texas State Senate, Senate Bill 162, 75th Legislature, 1997.
[7] Texas State Senate, Senate Bill 283, 77th Legislature, 2001.
[8] Texas House of Representatives, House Bill 727, 78th Legislature, 2003.
[9] Texas House of Representatives, House Bill 1771, 79th Legislature, 2005.

coordinate care from a network of providers. Services include health risk assessments for those who suffer from chronic diseases or are at risk for developing a chronic disease, home health services, case management, and an after hours nurse telephone service. The program also established a mechanism by which providers who met clinical guidelines and performance measures, offered after-hour clinics, and implemented measures to improve patient safety would receive a higher payment. The program was implemented on September 1, 2006.

Most recently, the 80th Legislature passed Senate Bill 10, which made many changes to Medicaid that attempt to refocus the program on prevention.[10] Among the many components of this bill is the Healthy Lifestyles pilot provision, which requires HHSC to develop and implement a pilot program in one area of the state. The pilot must provide Medicaid recipients positive incentives to lead healthy lifestyles through participation in certain health-related programs or engaging in certain health-conscious behaviors. In accordance with this requirement, HHSC has developed a tobacco cessation pilot program for Medicaid members in the Bexar County service area who are enrolled in the STAR-PLUS program. STAR-PLUS is a Medicaid managed care program for disabled adults which also offers acute and long-term care. HHSC chose this segment of the population based on evidence showing that the incidence of tobacco use in Texas is higher among disabled persons (29.9 percent versus a state-wide rate of 19.8 percent). The pilot provides telephone and face-to-face tobacco cessation counseling services that provide education, motivation, and support. Cessation counseling is not currently covered under the Medicaid program. Pilot participants will be randomly assigned to one

[10] Texas State Senate, Senate Bill 10, 80th Legislature, 2007.

of three groups: those receiving telephone cessation counseling, those receiving face-to-face cessation counseling, and a control group. Participants will be asked to complete four surveys over the course of the pilot and will receive a $20 gift card upon completion of each survey. The pilot program begins on October 1, 2008 and will end in December 2009, with a final report due to the legislature on December 1, 2010.[11]

The Chronic Care Model

The chronic care model is a research and evidence-based model for the delivery of effective chronic disease care. Designed and tested by Edward H. Wagner, M.D., M.P.H. and his colleagues at the MacColl Institute for Healthcare Innovation, the model involves not only the patient but also the provider practice, insurers, state agencies, employers, communities, and community organizations. It is designed around six elements: self-management support, delivery system design, decision support, clinical information systems, community, and health systems.

Self-management support refers to the practice of involving patients in lifestyle changes and developing illness management skills using education, goal setting, action planning, problem solving, and follow-up. *Delivery system design* involves transforming community practices from reactive physician models to proactive models that use multidisciplinary care teams to provide planned care at each appointment, including using group appointments, telephone and e-mail consultations. *Decision support* refers to the process of basing care on effective evidence-based care guidelines and using systems to

[11] Texas Health and Human Services Commission, *Testimony before the Senate Committee on Health and Human Servcies,* (Austin, Texas, August 26, 2008).

inform and prompt providers and patients about care needs. *Clinical information systems* are relatively simple systems used by clinical practices to track and coordinate patient information. The *community* element involves resources and programs within the community to support a healthier lifestyle, such as bike paths. The *health systems* element relates to creating a quality-oriented culture for providers through commitment to practice leadership, incentives for quality improvements, and strategies realigning reimbursements with desired levels of care.[12]

Between 1999 and 2003, a research team from the RAND Institute and the University of California at Berkley conducted an in-depth evaluation of 51 sites that had applied the chronic care model. The study was conducted across four health care collaboratives, involving nearly 4,000 patients suffering from diabetes, congestive heart failure, asthma, and depression. Fifteen separate reports stemmed from this research, including one that concluded that health interventions that contain one or more of the six elements of the chronic care model have improved clinical outcomes for patients with chronic illnesses more than those without any of the chronic care model elements.[13] Other studies have found that chronic heart failure patients treated according to the chronic care model had 35 percent fewer hospital days, and that patients with diabetes being treated according to the chronic care model had significant decreases in their risk of cardiovascular disease after treatment.[14] [15]

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[12] T. Bodenheimer, E.H. Wagner and K. Grumback, *Improving Primary Care for Patients with Chronic Illness*, Journal of the American Medical Association, Vol. 288, October 2002, p. 1775-79.
[13] A.C. Tsai, et. al, *A Meta-Analysis of Interventions to Improve Chronic Illness Care*, American Journal of Managed Care, Vol. 11, 2005, p. 478-88.
[14] Steven M. Asch, et. al, *Does the Collaborative Model Improve Care for Chronic Heart Failure?*, Medical Care, Vol. 43, no. 7, july 2005, p. 667-675.
[15] *Iibid,* p. 1775-79.

State and Local Initiatives for Improving Chronic Care Management: Case Studies

Vermont: Comprehensive Chronic Care and Medical Home Program for All Residents

In 2006, Vermont lawmakers passed legislation enacting the Vermont Blueprint for Heath, a statewide public-private initiative based on the Chronic Care Model designed to improve care for patients with chronic conditions and cut costs for the state. The Blueprint was originally introduced in 2003 and was enacted in 2006 as part of the state's larger health care reform package.[16] The Blueprint, the state's mandated standard for chronic care management across all payers and providers, was enhanced in 2007 when Vermont lawmakers authorized the creation of medical homes for chronically ill patients through a pilot program.[17] The Blueprint centers around six core system competencies, similar to the six elements of the chronic care model: public policy, community, self-management, information systems, health care practice, and health systems.[18]

The medical home concept is an approach to providing comprehensive primary care while addressing these six areas. The American Academy of Pediatrics (AAP) introduced this concept in 1967, referring to a central location for archiving a child's medical record. In its 2002 policy statement, AAP expanded the concept to refer to primary care that emphasizes timely access to medical services, enhanced communication between patients and their health care team, coordination and continuity

[16] Vermont Department of Health, *Vermont Blueprint for Health: 2007 Legislative Update*, 2007, p. 1.
[17] Anna Wolke, *Vermont Pilots Medical Homes for the Chronically Ill*, National Conference of State Legislators State Health Notes, Vol. 29, Issue 519, July 7, 2008, p. 1.
[18] Presentation by Paul Jarris, Executive Director of the Association of State and Territorial Health Officials *The Vermont Blueprint for Health: A National Perspective*, March 25, 2008.

of care, and an intensive focus on quality and safety.[19] The Medical Home model used in the Vermont legislation formed the basis for a request for proposals (RFP) sent to the six designated Blueprint communities in late 2007. Thus far, two communities have been given grants for the medical home pilot. The ultimate goal of the pilot is to establish a functional infrastructure that is replicable, scalable to different communities, and financially sustainable. Specifically, the pilot programs are expected to make progress in chronic disease care in the following areas which correspond to the Blueprint's six core competency categories:

- Financial reform through the design of a provider payment structure to support clinical transformation and incentives for high quality care;
- A clinical tracking system is required in each pilot community with the capacity to support clinical operations of a medical home. The tracking system will support disease management for the most prevalent chronic diseases, produce reports that direct individual patient treatment, facilitate e-prescribing, promote behavioral changes among patients by tracking self-management activities and progress, and support interactions between primary care providers and local care support teams;
- Process evaluation and improvement through provider Microsystems training which uses structured reports to identify areas for improvement, strategic planning to meet practice objectives, tracking measures, and making modifications to practices based on results of evaluations;

[19] T. Bodenheimer, E.H. Wagner and K. Grumback, *Improving Primary Care for Patients with Chronic Illness*, Journal of the American Medical Association, Vol. 288, October 2002, p. 1775-79.

- Community Care Teams (CCT), which are local multidisciplinary groups of professionals designed to account for the complexities involved in controlling or preventing chronic health conditions, help primary care providers coordinate the best care possible, minimize barriers by providing easy access to services, and help engage patients and their families in ongoing care, including self-management and behavioral change components;
- Community Prevention Teams (CPT) in each of the 12 regions of the state assess the prevention needs of the community, identify resources and community readiness to address these needs, develop and implement a community prevention plan, oversee grants to communities for prevention initiatives, and evaluate the efforts to improve wellness outcomes in the community, and;
- Pilot evaluation and a model for data management, analysis and reporting.[20]

Collected data relating to the outcomes of the Blueprint and the medical home pilots are not yet comparable across the state. However, anecdotal outcomes from each of the six core competency categories are worth noting.

- Public Policy: several initiatives have been introduced which supplement and/or compliment the Blueprint, including the creation of Catamount Health, a comprehensive and low-cost form of private insurance including premium assistance for low-wage workers; Fit and Healthy Vermonters, an obesity management program; and the Drug Enforcement, Treatment, Education, and

[20] Vermont Department of Health, *Vermont Blueprint for Health 2007 Annual Report*, January 2008, p. 7-13.

Recovery (DETER) program to address substance abuse, a significant health concern in the state.

- Community: Communities across the state have year-round walking programs for all ages and farmers' markets have doubled in recent years.
- Self-Management: Widespread attendance has been recorded at the "Healthier Living Workshop," an evidence-based program developed by Stanford University which teaches self-management of chronic conditions through a variety of skill-building techniques, which are held at 14 sites across the state. As of November 2007, 74 workshops had been held for 856 participants, and 581 participants had successfully completed the six-week course. Sixteen additional workshops were scheduled from January through May 2008, so these numbers are likely to be higher now.
- Information Systems: The largest part of the budget for the Blueprint for Health in 2006 (66 percent) went toward creating a clinical registry system, an information system that supports medical decision-making through built-in clinical standards to guide clinical care for individuals and targeted populations, providing reminders for recall visits, providing timely information from labs and specialists, and providing emergency rooms with immediate access to patient medication lists. Additionally, the state has developed a multi-payer database of claims information to help analyze the efficiency and effectiveness of the entire health care system.
- Health Care Practice: Practices across the state have adopted best practices clinical standards for patient care and microsystem changes.

- Health Systems: Patients are being provided with connections to other parts of the health care system as well as community organizations and programs. Also, the use of e-health has been used to link information and resources to the provider and patient.[21]

The Blueprint also includes a Strategic Plan that serves as a guide for operational planning and implementation, as well as a reference for evaluation of the Blueprint over the next five years (2007-2012). During 2006, the first year of implementation, the Blueprint was expanded from two to six communities. In preparation for expansion beyond these six communities, grants have been awarded to communities to assess infrastructure availability, develop coalitions and walking programs, and engage residents in physical activity. Nearly 75 percent of all primary care providers in the state have signed on to participate in the Blueprint. Additionally, the Provider Practice Workgroup, a statewide coalition of health professionals, is advising the Blueprint on clinical issues.[22] The Blueprint, and in particular the medical home pilot program, has been recognized nationally as a successful approach to addressing chronic disease management, and has been recognized by the Institute for Healthcare Improvement (IHI) as one of 13 notable health care reform demonstration programs globally. The leaders of these 13 programs interact regularly to share best practices on comprehensive health care reform.[23]

[21] Vermont Department of Health, *Vermont Blueprint for Health 2007 Annual Report*, January 2008, p. 14-29.
[22] *Ibid.*
[23] Vermont Department of Health, *Vermont Blueprint for Health: 2007 Legislative Update*, 2007, p. 3-4.

Indiana: Comprehensive Chronic Disease Management for Medicaid Recipients

While many lessons can be learned from the Vermont program highlighted above, the state has fewer uninsured citizens and a much smaller and significantly healthier population than Texas. Other states with populations more similar to Texas have adopted programs that deal with the chronic health care needs of certain specific populations, such as Medicaid recipients. One state that has done so in recent years is Indiana, where the Indiana Chronic Disease Management Program (ICDMP) targets diabetes, congestive heart failure, asthma, and chronic kidney disease among Medicaid recipients in an attempt to improve the quality and cost-effectiveness of care for these diseases. The stated goal of the program is to build a comprehensive, locally-based infrastructure that is sustainable and that will strengthen the existing public health infrastructure and help improve the quality of health care among all populations, not just Medicaid recipients.[24]

Once members have been identified as eligible for the program, they are divided into one of two groups: lower severity patients who receive telephonic care management through a centralized call center, or members identified as high severity who are assigned to a nurse care management network. For those who receive telephonic care management, trained non-clinical personnel, called Care Coordinators, are supervised by registered nurses. Care Coordinators call participants quarterly in order to conduct health assessments and provide educational materials to program participants, stimulate self-care, and encourage the provision of core medical care. The Care Coordinators use information system software which supports outbound telephone calls with a branching structure tailored to

[24] Indiana Chronic Disease Management Program, accessed at http://www.indianacdmprogram.com.

participant responses. The system also stores multiple-choice and free text responses for future analysis. The branching structure assists in identifying which chronic disease(s) the patients have and determines if follow-up calls with nurse care managers are necessary. For Medicaid recipients who are classified as high severity, Nurse Care Managers work with the members' primary medical providers to deliver a consistent message regarding management of chronic diseases. Nurse Care Managers also provide one-on-one assessments and education to participants for a four to six month intervention period involving home visits and accompaniment to doctor's appointments to establish a medical home. Following the intervention period is a two month reinforcement phase during which participants are transitioned to the call center for ongoing, quarterly assessments.

Nurses must have a bachelor's degree in nursing and at least one year of experience in a community health setting or bachelor's work equivalent of a formal nursing certificate with at least three to five years of work experience in public health or chronic disease management. The nurses currently working within the ICDMP have extensive experience with chronic illnesses in a variety of settings, including residential and home health care as well as family practices and clinics. In addition to the centralized call center and the nurse care management network, the ICDMP features an Indiana-specific version of a Chronic Disease Management System (CDMS), an internet-based electronic medical record and information system electronic disease registry. CDMS is used to enhance communication about the patient among participants involved in the member's care as well as the member's physician. CDMS contains clinical and claims information

on individual members, and is also used to track health assessments, schedule patient contacts, and contain the individualized care plans.[25]

One of the most important features of the ICDMP is the evaluation mechanism. Indiana consulted with the Regenstrief Institute, a non-profit health care research organization affiliated with the Indiana University School of Medicine, in order to measure the program's success in improving health outcomes and saving money. Regenstrief assisted the state in developing a randomized controlled trial (RCT) in two large urban group practices, the first trial of its kind among Medicaid disease management program evaluations. Both groups in the RCT had similar characteristics, but one group received treatment while the other did not, which makes differences in outcomes more easily attributable to the ICDMP, as opposed to other evaluation models.[26] According to the results of this evaluation, which studied patient behavior, hospitalization rates, drug utilization, and member satisfaction from September 2003 through May 2005, the most significant results were found in the population with congestive heart failure. Costs for this control group were reduced by over $720 per member per month. When projected for the entire program, the findings indicate ICDMP could generate a savings as great as $29 million for the state.[27]

[25] Indiana State Department of Health, *Chronic Disease Management Program Could Save Millions*, October 12, 2005, p. 1-2.
[26] *Ibid*, p. 2.
[27] *Ibid*, p. 2.

New York City: Food Calorie Labeling Regulation

In 2006, a regulation was passed in New York City requiring food service establishments (FSEs) that provide standardized menu items for which calorie information is publicly available on or after March 1, 2007 to post calorie content on menu boards and menus next to each menu item. This regulation applied to about 2,400 restaurants from 45 chains. The regulation did not apply to establishments that had not already made caloric information available to customers, and gave affected establishments until July 1, 2007 to comply. However, in June 2007, the New York State Restaurant Association filed a lawsuit challenging the city's new menu labeling ordinance, claiming that it was preempted by the Nutrition Labeling and Education Act (NLEA) of 1990, a federal law that requires food manufacturers to provide nutritional information on nearly all packaged foods, but explicitly exempts restaurants. A New York District judge agreed and repealed the regulation and the city responded by adopting a new version of the ordinance, which essentially carries the same requirements and went into effect on April 21, 2008. City Health Department officials expect the ordinance to prevent 130,000 New Yorkers from becoming obese and help another 30,000 from developing diabetes over the next five years.[28]

Fifteen states have introduced menu-labeling legislation thus far and several more are considering such measures. According to a 2006 study, 75 percent of U.S. adults report using nutrition labels on packaged foods and 50 percent say this nutritional information influences their food purchases. When nutritional information is readily available,

[28] Mark Hamblett. *New York City Wins Bid to Force Fast-Food Chains to List Calorie Count on Menus*, Law.com, April 17, 2008.

consumers choose high-calorie items about 33 percent less often. According to the USDA, healthier diets could prevent at least $71 billion per year nationwide in medical costs, productivity losses, and lost lives.[29]

California: Banning the Use of Fatty Acids

In July 2008, the state of California enacted Assembly Bill 93, which will prohibit restaurants from using trans fatty acids in food preparation, including oil, margarine, and shortening.[30] The legislation takes effect January 1, 2010 for oil, margarine, and shortening used in spreads or for frying, and further prohibits restaurants from using trans fats to deep-fry yeast dough and in cake batter, effective January 1, 2011. New York City, Philadelphia, Seattle, and Montgomery County, MD have all passed ordinances banning trans fats in restaurants, but California is the first state to do so.[31]

Tobacco Cessation

Tobacco use is the leading preventable cause of premature death and illness in Texas.[32] The adult smoking rate in Texas dropped below 20 percent to 18.1 percent for the first time in 2006, below the national average of 20.2 percent, but 3 million Texans continue to smoke and 24,000 die from tobacco-related illnesses each year.[33] Overall, the annual tobacco-related financial burden in Texas is over $12 billion per year, or $10 per pack of

[29] Presentation of the Association of State and Territorial Health Officials *The Vermont Blueprint for Health: A National Perspective*, March 25, 2008.
[30] California State Assembly, Assembly Bill 93, 2007-2008 Session.
[31] The Associated Press, *California Bans Trans Fats in Restaurants*, July 25, 2008.
[32] Centers for Disease Control and Prevention, Office on Smoking and Health, *Sustaining State Programs for Tobacco Control: Data Highlights*, 2006.
[33] Texas Department of State Health Services, *DSHS Boosts Resources to Help People Stop Smoking in New Year*, January 4, 2008.

cigarettes sold.[34] Tobacco use is particularly high among the Medicaid population. In 2000, 23 percent of the general population smoked, compared with 29 percent of adult Medicaid recipients.[35] In 2004, tobacco-related medical costs totaled $5.83 billion, $1.62 billion of which were through Medicaid, while losses in productivity attributable to tobacco use in 2004 totaled $6.45 billion. According to a study published by the American Legacy Society, Texas Medicaid expenditures would be reduced by 5.6 percent five years after all current smokers quit, a reduction of $498 million. If only 5 percent of smokers quit, savings would total $25 million; if 10 percent quit, savings after five years would total $50 million; if 25 percent quit, savings would total $125 million; and if 50 percent quit, savings after five years would total $249 million.[36]

Policy Options for Tobacco Cessation in Texas

Increased Funding

Increased funding for tobacco prevention efforts can be accomplished through higher taxes, redirection of settlement funds, or redirection of excise tax revenues. Increases in tobacco excise taxes are often seen as the most effective tool in achieving tobacco cessation. According to a 2000 Surgeon General's report, for every 10 percent increase in the price of cigarettes, demand declines by four percent among the general population and by seven percent among youth. Texas ranks 19th in terms of cigarette taxation levels and, after a 40 cent increase in the excise tax in 2007, is above the mean national level of

[34] Igor Gorlach and Eduardo J. Sanchez, University of Texas Health Science Center at Houston School of Public Health, *The State of Tobacco Control in Texas- 2007*, October 25, 2007, p. 2.
[35] Helen A. Halpin, Nicole M. Bellows and Sara B. McMenamin, *Medicaid Coverage for Tobacco-Dependence Treatments*, Vol. 25, No.2, March/April 2006, p. 550.
[36] American Legacy Foundation, *Saving Lives, Saving Money II: Tobacco-Free States Spend Less on Medicaid*, Policy Report 4, November 2007, p. 12.

$1.184.[37] Due to the 2007 tax increase, increasing the cigarette excise tax may not be the most feasible option at this time.

Another option for increasing funding is to redirect funds from the Texas Tobacco Settlement. Texas was one of four states to settle with the tobacco industry prior to the November 1998 multi-state settlement agreement. The tobacco industry agreed to pay the state an initial $1.3 billion dollars in 1999 and between $326.3 million and $560 million a year following that, for a total of $15 billion over 25 years. Additionally, the tobacco industry paid $2.3 billion to state counties and hospital districts, for a total of about $17.3 billion.[38]

The legislature allocated $1.5 billion of the total settlement amount to create permanent endowments for higher education and health and human services, using the interest earned from this allocation to fund ongoing programs. The initial allocation for tobacco education and enforcement was $200 million, about 7.5 percent of the initial $1.5 billion permanent endowment funding. The majority of the initial permanent endowment funding was allocated to health-related endowments and a permanent health fund for higher education. Each year, tobacco settlement receipts are allocated among health and human services and health-related higher education programs. A large amount of this is typically used to fund the State Children's Health Insurance Program (SCHIP). For the 2002-03 fiscal year, $18 million of the total $1.08 billion settlement receipt was allocated

[37] Campaign for Tobacco-Free Kids, *State Cigarette Tax Rates*, August 1, 2008, p. 2.
[38] Campaign for Tobacco-Free Kids, *A Broken Promise to Our Children: The 1998 State Tobacco Settlement Nine Years Later*, December 12, 2007, p. 86-87.

to tobacco education and enforcement and $10 million was allocated for tobacco prevention.[39]

A third option for increasing funding for tobacco prevention and control efforts is to redirect excise tax revenues, earmarking a portion for prevention initiatives. The 79th Legislature, in its 3rd called session, raised the excise tax on tobacco from $1.00 to $1.41 per pack. The Senate passed an amendment earmarking five percent of the tax revenue for tobacco control and prevention.[40] However, the House did not include this provision in the final version of the bill.

Statewide Clean Indoor Air Policy

Although there is currently no state-wide indoor smoking ban in place in Texas, many municipalities have enacted their own smoking ban ordinances. As of 2007, 27 percent of Texans were covered by a comprehensive smoke-free ordinance. Over the past several years, many states and localities have enacted such laws, and as of January 2008, 22 states, Puerto Rico, and the District of Columbia had 100 percent smoke-free laws, while two more states will have such laws in place effective January 1, 2009. Additionally, over 2,500 municipalities have clean indoor air laws.[41] During the 80th Legislature, the Texas Smoke-Free Workplace Law (House Bill 9/Senate Bill 368) was passed by the House and the Senate Committee on Health and Human Services, but was not considered

[39] Texas Department of State Health Services, *Tobacco Settlement Information*, Online: http://www.dshs.state.tx.us/tobacco/settlement.shtm, Accessed on July 1, 2008.
[40] Texas House of Representatives, House Bill 5, 79th Legislature, Third Called Session, 2006.
[41] Michael Eriksen and Frank Chaloupka, *The Economic Impact of Clean Indoor Air Laws*, CA: A Cancer Journal for Clinicians, Vol. 57, 2007, p. 368.

on the Senate floor prior to the end of session.[42] The bill would have added Chapter 169 to the Health and Safety Code, prohibiting smoking in public places, places of employment including bars and restaurants, and other places.[43]

The primary concerns that have been raised regarding a state-wide clean indoor air law are whether it is the appropriate role of government to regulate such a matter, the economic impact of such a law on restaurants and bar revenues, and the difficulty involved in enforcing such a law. Studies have been conducted to address the second and third issues raised. With regard to the economic impact of clean indoor air laws, a 2000 study conducted by the Texas Department of Health (now the Texas Department of State Health Services) reviewed how fully-implemented clean indoor air laws in four Texas cities (Austin, Arlington, Plano, and Wichita Falls) affected restaurant revenues. The study used regression analysis to examine Comptroller data on quarterly taxable restaurant sales over eight years. The findings showed that regardless of implementation date, demographics, geographic location, or economic composition of the four cities, all of them showed evidence of an increase in restaurant revenues following implementation of the ordinance.[44] Another study evaluated restaurant and bar revenues in 15 cities in California following the implementation of the statewide clean indoor air law in that state

[42] Texas House of Representatives, House Bill 9, 80th Legislature, 2007; Texas State Senate, Senate Bill 368, 80th Legislature, 2007.
[43] Texas Legislative Budget Board, *Fiscal Note for the 80th Legislative Regular Session regarding HB 9*, May 16, 2007.
[44] James A. Hayslett and Phillip P. Huang, Texas Department of Health Bureau of Disease, Injury and Tobacco Prevention , *Impact of Clean Indoor Air Ordinances on Restaurant Revenues in Four Texas Cities: Arlington, Austin, Plano and Witchita Falls 1987-1999*, March 21, 2000.

and found that effects on restaurant and bar revenues were not statistically significant.[45] In a third study, economists found that after smoke free laws were passed in California in 1995 and again in 1998, bar and restaurant revenues actually experienced a slight increase.[46]

In terms of enforcing statewide indoor smoking laws, a study based on case studies from seven states and nineteen jurisdictions that have enacted such laws found that, in most cases, state enforcement activity of such laws is delegated to local health departments. Additionally, the study found that statewide laws are typically not systematically enforced by state or local authorities, but are largely self-enforcing, with citizens voluntarily complying with the law in the absence of a systematic enforcement effort. This voluntary compliance is explained as primarily the result of changing societal norms regarding smoking in public places. Another study concluded that, in general, smoke-free policies are self-enforcing and that compliance is usually high within a short period of time.[47] Possible barriers to the effective enforcement of such a law are resource constraints, fragmented enforcement authority, ambiguous legal authority, and preemption issues.[48]

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[45] Stanton A. Glantz and Lisa R. A. Smith, American Journal of Public Health, *The Effect of Ordinances Requiring Smoke-Free Restaurants and Bars on Revenues: A Follow Up*, Vol. 87, No. 10, October 1997, p. 1687.
[46] David W. Cowling and Philip Bond, Health Economics, *Smoke-free Laws and Bar Revenues in California- Last Call*, Vol. 14, 2005, p. 1273-1281.
[47] Michael Eriksen and Frank Chaloupka, *The Economic Impact of Clean Indoor Air Laws*, CA: A Cancer Journal for Clinicians, Vol. 57, 2007, p. 371.
[48] Peter D. Jacobson and Jeffrey Wasserman, Journal of Health Politics, Policy and Law, *The Implementation and Enforcement of Tobacco Control Laws: Policy Implications for Activists and the Industry*, Vol. 24, No. 3, June 1999, p. 584-587.

Comprehensive Programs

Comprehensive programs to reduce tobacco use incorporate several tobacco control intervention methods, including in-school programs, community measures, cessation programs, enforcement, smoking bans, tax increases, and media campaigns. The National Academies of Science Institute of Medicine (IOM) and the Centers for Disease Control and Prevention (CDC) have recommended that comprehensive tobacco control programs include these elements along with chronic disease programs, state-wide programs, and counter-marketing of tobacco products.

Although minimal research has been conducted on the return on investment for comprehensive programs, a report by the Center for Health Research Kaiser Permanente Northwest analyzed the return on investment for the Texas Tobacco Prevention Initiative and concluded that there was a $252 million return on the $11.3 million spent on the program during 2003 in counties with $2.71 per capita spending. Applying current trends to predict the return on investment for a state-wide program implies that a $3 per capita investment will yield a $5.8 billion return for the state.[49]

In Texas, comprehensive programs are carried out through the Texas Tobacco Prevention Initiative (TTPI), which was started in 1999 using a portion of the $17.3 billion awarded to the state in the Texas Tobacco Settlement. The state legislature appropriated interest from the initial $200 million allocation to the Permanent Endowment for tobacco education and enforcement to DSHS to prevent tobacco use and promote cessation.

[49] The Center for Health Research, Kaiser Permanente, *The Business Case for Tobacco Cessation: WEB ROI*, 2007.

DSHS initiated a pilot study in 18 Texas communities, which showed that comprehensive programs had a significant impact on smoking levels. According to the agency, surveys evaluating the impact of the Texas Tobacco Prevention Initiative on tobacco use in areas where the program has been funded at $3 per capita (determined by DSHS and local partners as the optimal per capita amount that should be spent for comprehensive programs to be effective) show that the rate of tobacco use among youth in grades 6 through 12 was reduced by 40 percent between 2000 and 2006. Additionally, the rate of tobacco use among adults ages 18-22 was reduced by 25.5 percent from 2000 to 2004. The 79th Legislature reduced funding for tobacco education and enforcement by 10 percent, and currently only Jefferson County community programs are being funded at the optimal $3 per capita level.[50] DSHS is also responsible for other initiatives focused on tobacco cessation and prevention, including a Quitline in partnership with the American Cancer Society, tobacco prevention and control coalitions, an interagency contract with the Texas Education Agency (TEA) to prevent tobacco use among school-aged children, smokeless tobacco prevention education, and targeted media messages, among others.[51]

According to the CDC's Office on Smoking and Health Tobacco Control Program, each state can receive approximately $1 million a year for comprehensive tobacco control programs. Suggested levels of funding from all state sources (including excise tax revenue and Master Settlement Agreement payments) per capita are also included and

[50] Department of State Health Services, Mental Health and Substance Abuse Division, *Progress on Achieving Taxes Tobacco Reduction Goals: A Report to the 80th Legislature*, December 2006, p. 3.
[51] Department of State Health Services, *Testimony before the Senate Committee on Health and Human Services,* Austin, Texas, August 26, 2008.

total $5.85 to $15.85 depending on size and population. In general, states are not funding efforts at these levels. In fiscal year 2005, the mean per-capita expenditure in Texas was $2.76. The same year, the state received $24.74 per capita in Master Settlement Agreement payments and $23.6 per capita in tobacco excise tax revenues, but spent only $0.35 per capita on tobacco prevention spending.[52] The CDC recommends that Texas spend between $103 million and $284.7 million a year in order to have an effective, comprehensive tobacco prevention program. In fiscal year 2007, Texas ranked 45th among all states in tobacco prevention spending, at $5.2 million in annual funding. In fiscal year 2008, Texas ranks 42nd in terms of prevention funding, spending $11.8 million, or 11.4 percent of the minimum recommended CDC amount.[53]

Obesity Reduction

Being overweight or obese is linked to many health problems, including heart disease, stroke, type 2 diabetes, and several types of cancers. Since these diseases are not only the most costly diseases but also the most preventable, many wellness programs and policies focus on controlling and preventing the incidence of being overweight or obese. Obesity has increased dramatically across the country over the past two decades and, as of 2006, 65 percent of U.S. adults ages 20 and older were classified as either overweight or obese, which is defined as having a Body Mass Index (BMI) of 30 or higher. Children have been increasingly affected by the surge in obesity, and now 16 percent of all American

[52] Campaign for Tobacco-Free Kids, *A Broken Promise to Our Children: The 1998 State Tobacco Settlement Nine Years Later*, December 12, 2007, p. 86-87.
[53] *Ibid*, p. 86-87.

school-age children are obese or overweight. This is twice the number of children who fell into this category 20 years ago.[54]

The obesity problem is even more severe in Texas, where the adult overweight and obese rate is similar to the national rate (64 percent), but the incidence of childhood overweight and obesity is 35 percent, more than double the national rate of 16 percent.[55] Currently, Texas is ranked as the 15th fattest state in the country.[56] The obesity rate has increased dramatically in Texas over the past two decades. In 1990, 12.3 percent of the state's adult population were obese and this number grew to 27 percent by 2005. In comparison, the national rate of adult obesity was 24.4 percent in 2005. This amounts to a 49.4 percent increase in the incidence of adult obesity or overweight over a period of 15 years. If the current trends continue, the Comptroller of Public Accounts (CPA) predicts that by the year 2025, 48.6 percent of adult Texans will be obese and only 14.4 percent will be normal weight.[57] The issue has affected children in particular, with Texas having the 6th highest percentage of overweight and obese children.[58] In a study of Texas children conducted between 2004 and 2005, researchers found that 42 percent of fourth-graders were overweight, at risk of becoming overweight, or obese, as were 39 percent of eighth graders and 36 percent of eleventh graders.[59]

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[54] Texas Health Institute, *Obesity in Texas: Policy Implications*, August 4, 2006, p. 1.
[55] *Ibid*, p. 1.
[56] Trust for America's Health, *F as in Fat: How Obesity Policies are Failing in America*, 2008, p. 10-11.
[57] Texas Comptroller of Public Accounts Special Report, *Counting Costs and Calories: Measuring the Cost of Obesity in Texas*, March 2007, p. 1.
[58] *Ibid*, p. 11.
[59] Deanna M. Hoelscher, et al., *School Physical Activity and Nutrition (SPAN) III Survey, 2004-2005*. UT School of Public Health, Houston, 2005.

Areas with concentrated Hispanic populations have the highest obesity and overweight prevalence. Thirty two percent of adult Hispanic Texans are obese, compared to 25 percent of whites and 27 percent of the entire adult population; 37.4 percent of the adult population in the lower south Texas region are obese; the highest prevalence in the state. Additionally, 66.4 percent of adults in San Antonio are overweight or obese, the highest prevalence of any city in the state.[60]

Costs of Obesity in Texas

The detrimental effects of obesity on individuals' health also has a significant impact on taxpayers due to the costliness of resulting diseases and the preventable nature of those diseases. Taxpayers are affected in multiple ways. First, the incidence of obesity within the Medicaid population is much higher than in the general population. A study conducted from 1998-2000 found that while 22 percent of Texan adults were obese over this time period, 35.8 percent of the state's Medicaid population were obese. Medicaid and Medicare costs attributable to obesity in Texas exceed $5 billion annually. Taxpayers are also affected by a new Governmental Accounting Standards Board rule (GASB 45) requiring that states and localities report their total unfunded actuarial accrued retiree health plan liabilities for 30 years. This figure is likely to be substantial due in part to obesity among state employees and could affect the government's bond rating, making it more costly for the state to borrow money.[61]

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[60] *Ibid*, p. 2.
[61] Texas Comptroller of Public Accounts Special Report, *Counting Costs and Calories: Measuring the Cost of Obesity in Texas*, March 2007, p. 2-3.

Since more than half of adult Texans have employment-based health insurance, Texas employers are often forced to pay the costs of medical care caused by obesity and have faced sky-rocketing health care costs in the past several years. Most adults with private health insurance coverage (88.5 percent) receive coverage from their employers, and Texas employment-based insurance premiums rose by 29.3 percent from 2001 to 2005. Therefore, Texas employers face the burden of paying for health care costs of employees that result from chronic conditions often caused by obesity. In 2005 alone, obesity cost Texas businesses $3.3 billion, most of which came from health care costs (41.4 percent) and presenteeism (37.4 percent), which refers to losses from decreased productivity at work. If this trend continues, obesity is projected to cost Texas businesses $15.8 billion annually by 2025.[62] Total costs of obesity-related diseases in Texas are expected to increase to $15.6 billion by 2010 and $39 billion by 2040.[63] Although tobacco-related illnesses result in more deaths than those caused by obesity, obesity generates more health care costs than tobacco use. On average, obese people spend 36 percent more on heath care services and 77 percent more on medications than their normal-weight counterparts; smokers spend 21 percent more on health care services and 28 percent more on medications than non-smokers.[64]

[62] Texas Comptroller of Public Accounts Special Report, *Counting Costs and Calories: Measuring the Cost of Obesity in Texas*, March 2007, p. 1-2.
[63] Texas Department of State Health Services, *Texas Obesity Policy Portfolio*, 2006, p. 5.
[64] Roland Sturm, *The Health Risks of Obesity: Worse than Smoking, Drinking or Poverty*, RAND Health, 2002, p. 2.

Current Programs

School-Based Programs

As discussed above, the obesity problem in Texas is especially pronounced in children, and since the Surgeon General estimates that overweight children have a 70 percent chance of becoming overweight or obese adults, school-based programs are popular policy tools for addressing obesity in the state. Research has also shown that childhood obesity is linked to poorer academic performance as well as a higher rate of absenteeism, providing an added incentive for improving the health of children in Texas.[65] [66] The Legislature has enacted several laws aimed at combating childhood obesity through increased physical activity, improved nutrition, and health education. In 2001, the 77th Legislature enacted Senate Bill 19, requiring the Texas Education Agency (TEA) to make a coordinated school health program available to all elementary school children.[67]

Among TEA-approved coordinated school health programs is the Coordinated Approach to Child Health (CATCH) program, which provides health education, physical education and physical activity, and nutrition services to children. SB 19 also allowed the State Board of Education (SBOE) to adopt a rule requiring students enrolled in kindergarten through 6th grade to participate in daily physical activity. The SBOE adopted this rule and it became effective at the beginning of the 2002-2003 school year. Additionally, SB 19 required each school district to establish a local health education advisory council to

[65] Pamela Schehl, *Study: Direct Link Between Student Health, Achievement*, Mount Vernon News, August 30, 2006.
[66] Loann Loviglio, *Study Links Childhood Obesity, Absenteeism*, Oakland Tribune, August 11, 2007.
[67] Texas State Senate, Senate Bill 19, 77th Legislature, 2001.

advise the school board on health education curriculum and to ensure that local community values are incorporated into health education curriculum.

The 78th Legislature enacted Senate Bill 1357, requiring TEA to make one or more coordinated school health plans available to all elementary school children and also required that TEA adopt criteria for evaluating the programs before making them available to school districts.[68] The bill also renamed local health education advisory councils as School Health Advisory Councils (SHACs) and required these Councils to create strategies to integrate health curriculum into a coordinated school health program, including school health services, counseling services, a safe and healthy school environment, and school employee wellness. Although every school district is required to have a SHAC, in practice many of them meet only once a year, have little if any parental involvement, and have little accountability to local school boards. Setting guidelines for SHACs could improve their effectiveness in promoting Coordinated School Health.

The 79th Legislature passed Senate Bill 42, requiring that health education emphasize the importance of proper nutrition and exercise.[69] It also allowed the SBOE to adopt a rule to require students in kindergarten through 8th grade to participate in daily physical activity as part of the district's physical education curriculum, and to require middle school and junior high school students to participate in physical activity twice a week. The bill also extended the Coordinated School Health program to all middle school and high school

[68] Texas State Senate, Senate Bill 1357, 78th Legislature, 2003.
[69] Texas State Senate, Senate Bill 42, 79th Legislature, 2005.

campuses and required each district to provide the Texas Education Agency (TEA) with data relating to student health and activity. Finally, the bill required HHSC to establish a School Health Advisory Committee at the department to assist local SHACs.

Most recently, in 2007 the 80th Legislature passed Senate Bill 530, which transfers authority over daily physical activity to TEA, strengthens the definition of daily physical activity to "moderate or vigorous" activity for kindergarten through 5th grade students, and restores the 30-minute requirement as a minimum, not a maximum.[70] Beginning with the 2008-09 school year, students in sixth through eighth grade will be required to participate in moderate or vigorous physical activity daily for at least four out of six semesters. Recess does not fulfill the requirement and the statute requires a physical fitness assessment of 3rd through 12th graders once per year.

During the program's first year, the TEA used the Fitnessgram program, created by The Cooper Institute, to test 2.6 million of the nearly 3.4 million Texas students in grades 3-12. The test consists of six physical fitness tests assessing aerobic capacity, body composition, muscular strength, endurance, and flexibility to determine whether or not children fall into the "Healthy Fitness Zone," a range of acceptable assessment results. The $2.5 million cost of the study was funded by private donations. The first assessment was successful, with an 84.5 percent compliance rate. Results of the first fitness assessment showed that overall physical fitness levels of Texas school children are poor and that, as children get older and physical activity is emphasized less and less in the curriculum, physical fitness deteriorates. Specifically, the assessment determined that about 32 percent of 3rd grade girls and 28 percent of 3rd grade boys, 21 percent of 7th

[70] Texas State Senate, Senate Bill 530, 80th Legislature, 2007.

grade girls and 17 percent of 7th grade boys, and 8 percent of 12th grade girls and 9 percent of 12th grade boys fall into the Healthy Fitness Zone. TEA Commissioner Robert Scott has said that about 15 states have expressed interest in utilizing such a program, and that Texas is the first state in the country to order a comprehensive physical assessment of its students.[71]

Also during the 80th Legislature, Article III of the Appropriations Act included Rider 89, which allocated $20 million for the 08-09 biennium to create Texas Fit Now, a grant program which would provide funds to economically disadvantaged middle schools to support in-school physical education, nutrition, and fitness programs.[72] The CPA and the TEA developed the program and set guidelines, and TEA is responsible for processing applications. In order to be eligible for one of the non-competitive grants, a school must serve 6th, 7th and 8th graders and 75 percent of the school's children must be categorized as economically disadvantaged. Approximately 700 schools with 272,000 students are eligible and schools were required to submit their applications by October 15, 2007. Every eligible school that meets certain requirements will be eligible to receive a base allocation of $1,500 and the remainder of the funding will be divided by enrollment, which amounts to $32 per student. Schools must allocate funds so that 25 percent of the program focuses on nutrition education and activities, and 75 percent centers on physical fitness education and activities. To date, more than 250,000 students from 605 schools have participated in the program.[73] Finally, House Bill 4062, also passed by the 80th

[71] Texas Education Agency, *Texas Tests Fitness of 2.6 Million Students; Finds Elementary Students are in Best Shape*, July 1, 2008, p. 1.
[72] Texas House of Representatives, House Bill 1, 80th Legislature, 2007.
[73] Michael Castellon, *The Economics of Obesity in Texas*, Fiscal Notes, May 2008, p. 4.

Legislature, directed the Texas Department of Agriculture (TDA) to prepare and submit a report no later than December 1, 2008 which contains information on it's and the U.S. Department of Agriculture's (USDA's) steps to reduce trans-fatty acids from all school meals and nutrition programs.

Worksite Wellness

School-based programs aimed at obesity reduction and general wellness are most effective for targeting children because they spend the majority of their time at school. Similarly, work-based wellness programs are the most effective means of targeting adults. Unlike school-based programs, worksite wellness programs provide the additional benefit of decreasing employee health care costs. Accordingly, many Texas companies are shifting their health care focus from disease treatment to prevention and wellness. The most successful of these programs offer financial incentives to employees, such as lower health insurance deductibles or company-paid gym fees, as well as other programs designed to encourage healthy lifestyles. Most of these programs take three to five years to show a return on investment. A 2002 Hewitt Associates survey reported that 81 percent of U.S. companies had adopted wellness programs to improve employee health, and 76 percent had disease management programs. Additionally, 72 percent had health education programs, 75 percent offered health screenings, 42 percent offered incentives to encourage healthy behavior, and 28 percent utilized health risk appraisals (HRA), which identify high health risk employees by checking risk factors such as blood pressure, weight. and blood cholesterol.[74] According to the most recent Hewitt Associate

[74] Texas Comptroller of Public Accounts Special Report, *Counting Costs and Calories: Measuring the Cost of Obesity in Texas*, March 2007, p. 2-4.

survey of major U.S. employers, this trend has continued, with 88 percent of them planning to make significant investments in longer term solutions aimed at improving the health and productivity of its workers.[75] Dr. Michael O'Donnell, editor-in-chief and president of the American Journal of Health Promotion, estimates that corporate wellness programs will grow by 30 percent annually over the next several years. He estimated the size of the corporate wellness industry at $550 million annually, in addition to $380 million spent on corporate fitness centers. Studies conclude that each dollar spent on wellness generates an average savings of $3.84 on health care expenses and $5.82 in reduced absenteeism costs.[76]

Examples of Texas companies that have successfully implemented health promotion programs include USAA, Dell, and H-E-B. In 2006, USAA, which is based in San Antonio and employs nearly 10,000 Texans, received the C. Everett Koop National Health Award recognizing excellence in health risk reduction and cost reduction programs. The company's wellness program, "Take Care of Your Health," includes over 20 workplace wellness initiatives, including smoking cessation and weight management programs, on-site health clinics, fitness centers and personal trainers, and healthy food choices available in cafeterias and vending machines. 68.5 percent of the company's employees participate in at least one of these initiatives, and the company has reduced workplace absences and produced an estimated three-year savings of more than $105 million. H-E-B, the largest independent grocery store in Texas and the employer of 69,000 Texans, implemented its "Healthy at H-E-B" wellness initiative which targets

[75] Hewitt Associates LLC, *Two Roads Diverge: Hewitt's Annual Health Care Survey 2008*, p. 3.
[76] Texas Comptroller of Public Accounts Special Report, *Counting Costs and Calories: Measuring the Cost of Obesity in Texas*, March 2007, p. 4-7.

unhealthy lifestyle behaviors of employees such as physical inactivity and smoking. Each participant receives a financial incentive for completing a health risk appraisal. By the fourth year of the program, 65-70 percent of its employees were participating, and while the company's health care costs were rising by 25 percent annually before the program began, they decreased by 3.7 percent in 2005 and increased by only 2.9 percent in 2006. The company originally offered an insurance premium deductable for participation in the program, but is now moving toward charging weekly premiums for not participating.[77] Dell, the Round Rock-based technology firm that employs 18,000 Texans, has implemented a comprehensive health and wellness program called "Well at Dell", which allows employees to choose and build their own health plans, including on-site wellness programs and a 24-hour health hotline.[78] Beginning in January 2009, the company will ban smoking on all of its domestic campuses. The company has indicated that it will offer free smoking cessation programs to employees as part of the initiative. Also beginning in 2009, Dell will provide a discount on health insurance premiums to all non-smoking employees.[79]

The 80th Legislature passed House Bill 1297, establishing a state employee wellness program in Texas.[80] The bill authorized HHSC to designate a statewide Wellness Coordinator responsible for developing a model statewide wellness program. The wellness program includes:

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[77] Texas Senate Committee on Health and Human Services, Testimony of H-E-B, Austin, Texas, August 26, 2008.
[78] Texas Comptroller of Public Accounts Special Report, *Counting Costs and Calories: Measuring the Cost of Obesity in Texas*, March 2007, p. 4.
[79] *Dell to Employees: Kick the Habit*, Austin Business Journal, June 26, 2008.
[80] Texas House of Representatives, House Bill 1297, 80th Legislature, 2007.

- An education component to target the most costly and prevalent diseases and provide information about stress management, nutrition, alcohol and drug abuse, physical activity, and smoking;
- Distribution and use of health risk assessment tools and programs including surveys to identify an employee's risk levels and methods for minimizing risks;
- Development of strategies for the promotion of health, nutritional, and fitness resources in state agencies;
- Development and promotion of strategies that integrate healthy behaviors and physical activity, including making healthy food choices available in snack bars, vending machines, and cafeterias in state buildings; and
- May include optional incentives to encourage participation in the wellness program.

Wellness programs have been established at several government agencies including the Comptroller of Public Accounts, DSHS, the Department of Aging and Disability Services (DADS), and the Department of Family Protective Services (DFPS). Other states have also implemented wellness programs and measures for state employees. Some use disincentives to affect behavior. In Alabama, for example, state employees are required to undergo free health screenings by January 2010. If those screenings reveal blood pressure or cholesterol problems or show employees to be obese based on Body Mass Index (BMI), the employee will have one year to seek treatment for those conditions. The Alabama State Employees Insurance Board has approved a plan to charge workers $25 per month if they fail to comply. The state expects to spend $1.6 million more in

2009 than in 2008 on screenings and wellness programs, but expect these expenses to be far outweighed by the expected savings in health care costs over time.[81]

Comprehensive Programs

Some legislation and policies addressing obesity in Texas combine elements including school-based programs, worksite wellness programs, community-based programs, and capacity building. In 1999, the CDC created the Nutrition and Physical Activity Program to Prevent Obesity and Other Chronic Diseases (NPAO). NPAO currently works with 28 states to build lasting and comprehensive efforts to address obesity and other chronic diseases through a variety of nutrition and physical activity strategies. In fiscal year 2007, NPAO funded 21 "capacity-building" states to establish state infrastructure, plan obesity prevention and control efforts, identify data sources to monitor the burden of obesity, collaborate and coordinate with public and private partners, and begin implementing interventions. Texas is among the states receiving funding for capacity building activities. In addition, seven "basic implementation" states were provided funding to implement a comprehensive nutrition and physical activity state plan to prevent and control obesity and other chronic diseases, provide training and technical assistance to communities, implement and evaluate nutrition and physical activity interventions to prevent obesity and other chronic diseases, and evaluate the progress and impact of the both state plan and interventions. The DSHS Nutrition, Physical Activity, and Obesity Prevention Program (Texas NPAO) was first funded in 2000 and the project lasts through 2008.[82]

[81] Health Care News, *Alabama to Penalize State Employees Deemed Obese*, Vol. 9, No. 5, November 2008.
[82] Texas Department of State Health Services, Government Relations staff, September 11, 2008.

Among other accomplishments, the Texas NPAO program has produced the Strategic Plan for the Reduction of Obesity: 2005-2010, released new child overweight statistics for 4th, 8th, and 11th graders, and launched the Texas Active Living Network (TALN). DSHS formulated the Strategic Plan for the Reduction of Obesity: 2005-2010 in conjunction with 69 stakeholders representing 59 agencies and organizations in the state. The strategic plan focuses on obesity prevention for all ages and sectors of society. The TALN provides information and education on building trails, bikeways, and other transportation, recreation, and conservation infrastructure to encourage active lifestyles for Texans. The TALN also develops and promotes programs to help Texans learn safe and effective ways to participate in physical activity as a part of an active lifestyle and coordinates efforts and policy among its members and similar organizations throughout the state for the benefit of all Texans.[83] Current initiatives of the Texas NPAO program include grants for community demonstration projects, a farm-to-work program, a statewide obesity partnership conference, technical assistance and training to communities on obesity prevention, and implementing the state employee wellness program as required in Senate Bill 1297.

The Interagency Obesity Council, another comprehensive effort to reduce obesity, was created by the 80th Legislature through Senate Bill 556.[84] This measure added Chapter 114 to the Health and Safety Code, creating the Council comprised of the Commissioners of DSHS, TDA, and TEA. The Council must meet at least once a year to discuss the

[83] The Centers for Disease Control and Prevention, Division of Nutrition, Physical Activity, and Obesity, *Obesity and Overweight: State-Base Programs: Texas*, Online at http://www.cdc.gov/nccdphp/dnpa/obesity/state_programs/funded_states/texas.htm, Accessed on June 3, 2008.
[84] Texas State Senate, Senate Bill 556, 80th Legislature, 2007.

status of each agency's programs that promote better health and nutrition and prevent obesity among children and adults and to consider the feasibility of tax incentives for employers who promote activities designed to reduce obesity in the workforce. The Council must report to the Governor, Lieutenant Governor, and Speaker of the House of Representatives by January 15 of each odd-numbered year. This report must include a list of each agency's wellness programs, an assessment of the steps taken by each program, progress made by taking these steps, areas of improvement that are needed in the programs, and recommendations for future goals or legislation. The report will detail all programs, initiatives, and proposals of the Council.

Public-Private Partnerships

Although no states have launched broad-based private sector programs, the Texas Coalition for Worksite Wellness (TCWW) was formed in late 2006 as a program of the Texas Business Group on Health to bring prominent Texas health care associations, providers and businesses together to develop and improve wellness and prevention programs in Texas. Coalition members include the Texas Association of Business, Texas Medical Association, Texas Hospital Association, American Heart Association, United Way of Texas, Blue Cross Blue Shield of Texas, CIGNA Healthcare, Sabre Holdings, Texas Instruments, and Pfizer.

Potential Policy Solutions

School-Based Programs

During the 80th legislative session, several measures relating to school-based physical activity and nutrition were introduced but not enacted. These bills may provide a starting point for possible legislation in the coming session. Senate Bill 418 would have directed DSHS and the Texas Department of Insurance (TDI) to develop evidence-based clinical guidelines to prevent and treat obesity. The measure would have authorized DSHS to provide guidelines to health providers, insurers, and health plans on obesity prevention and treatment.[85]

Senate Bill 34, also introduced but not passed by the 80th Legislature, would have codified the Texas Public School Nutrition Policy language in public law to prevent elementary schools from serving or providing access to foods of minimal nutritional value. It also would have authorized the Commissioner of TDA to adopt rules relating to the availability of foods of minimal nutritional value on school campuses.[86] Additionally, the measure would have established by rule the Public School Nutrition Policy and directed each school district with at least one participating campus to implement the nutrition policy. SB 34 would have also prohibited a school district or campus from providing or making available to students whole milk, food products containing excessive amounts of fat per serving, food products containing excessive amounts of fat or portion sizes larger than those approved by the Commissioner. Finally, the measure would have

[85] Texas State Senate, Senate Bill 418, 80th Legislature, 2007.
[86] Texas State Senate, Senate Bill 34, 80th Legislature, 2007.

encouraged school districts to adopt menus recommended by the Commissioner that increase the weekly servings of fresh fruit and vegetables and whole grain food.

Senate Bill 73, also considered but not passed by the 80th Legislature, would have amended Title II of the Texas Agriculture Code to expand the use of Texas agricultural products in public school breakfast and lunch meals in order to improve the quality, nutritional content, and cost-efficiency of the meals; allowed public school nutrition policy to be more stringent than any recommended or required federal guidelines; amended Chapter 38 the Texas Education Code to include nutrition services, which may include nutrition education for students and their parents; and provided for the establishment of school health performance measures.[87]

Several other states have passed laws and implemented programs to reduce obesity and improve overall wellness through school-based programs. Connecticut Public Law 06-63, enacted in 2006, restricts the types of beverages that may be sold in schools, requires the State Department of Education (SDE) to set nutritional standards each year for the foods sold in schools, and provides financial incentives for school boards, charter schools, and other schools to certify that their schools meet the SDE standards. School districts participating in the National School Lunch Program must decide and report to the Department each year whether they will offer only foods that meet the new standards. Districts that do so will receive an additional ten cents per lunch, up from the regular rate of five cents per lunch.

[87] Texas State Senate, Senate Bill 73, 80th Legislature, 2007.

Indiana Public Law 54-2006, also enacted in 2006, requires the Department of Education to provide information concerning health, nutrition, and physical activity. It also requires that at least 50 percent of food items sold in schools qualify as "better choice foods", with no more than 30 percent of calories from fat, and not more than 10 percent of calories from saturated fats.[88] Colorado, Maine and West Virginia have all enacted laws which provide students and parents access to the nutritional content of school foods either through a website, school menus sent home with children, or by posting the information in the cafeteria.[89]

Other proposals related to school-based programs include:

- Promoting and funding nutrition education in early childhood education, possibly through a grant program;
- Collecting data on PE class sizes and teacher certification rates in Texas schools;
- Encouraging high schools to establish community-based fitness activities for students to participate in outside of normal school hours; and,
- Establishing suggested criteria for new school construction that promotes physical activity.

Worksite Wellness

In addition to establishing a state employee wellness program in Texas, Senate Bill 1257, passed by the 80th Legislature, established a Worksite Wellness Advisory Board

[88] Robert Wood Johnson Foundation, *State Actions to Promote Nutrition, Increase Physical Activity and Prevent Obesity*, Balance, Issue 3, October 2006, p. 18-22.
[89] Texas Health Institute, *Obesity in Texas: Policy Implications*, August 2006, p. 7.

comprised of 17 members connected to DSHS.[90] The Board is responsible for creating a plan to improve the health of state employees and designing a public education/outreach campaign. Other states, including Arkansas, North Carolina, and Ohio, have implemented comprehensive wellness programs for all state employees. In Arkansas, the employee wellness program offers weight loss assistance, health maintenance, and nutrition programs for all state employees and teachers. Some policy makers in other states are also considering worksite cafeteria labeling programs that would, in conjunction with nutrition information, encourage employees to make better food choices. As mentioned previously, several employers provide employees with financial incentives to participate in healthier behaviors, including discounted gym memberships and constructing in-house fitness center facilities. Some states are now considering offering employers businesses tax incentives to implement such programs.[91] Other ways to promote worksite wellness include providing guidance to businesses on worksite wellness program design and implementation and supporting public sector wellness programs as models for the private sector.

Community-Based Programs

Although school-based and worksite wellness programs that address obesity are most common and are regarded as the most effective programs, some policy options focus on building healthier communities overall and tying other efforts together. Healthy community design programs, which aim to redesign communities to promote healthier lifestyles, offer another policy option for addressing obesity. This includes establishing

[90] Texas State Senate, Senate Bill 1257, 80th Legislature, 2007.
[91] Texas Comptroller of Public Accounts Special Report, *Counting Costs and Calories: Measuring the Cost of Obesity in Texas*, March 2007, p. 3.

tax incentives or exemptions for private donations of easements to expand walking or biking paths and requiring new developments to install sidewalks and internal connections forming a pedestrian bicycle network. For example, the city of Davidson, North Carolina offers a 30 percent reduction in transportation fees charged to a developer in return for pedestrian-friendly design features and an additional 20 percent reduction for transit-friendly features. Other policies to encourage healthy lifestyles and obesity reduction include eliminating the sales tax on exercise equipment, providing communities with after-hours access to recreational facilities, and addressing the lack of access to healthy foods in parts of the state as well as in specific neighborhoods within cities.

Immunizations

Currently, the U.S. has the highest immunization rate in its history, with 77 percent of children entering kindergarten completely up to date on vaccines and most of the remaining children lacking very few shots. The CDC estimates that fully vaccinating all U.S. children born in a given year from birth to adolescence saves 33,000 lives, prevents 14 million infections, and saves $10 billion in medical costs. Children generally receive 28 vaccines for 14 diseases by age two.[92] According to the 2006 National Immunization Survey (NIS), as of 2007, 77.3 percent of Texas children ages 19 through 35 months were fully vaccinated. This represents a 3.5 percent increase over the 2006 immunization level and ranks Texas as 22nd in the country, the highest ranking Texas has ever reached.[93]

[92] *How Safe are Vaccines?*, Time, June 2, 2008.
[93] The Centers for Disease Control and Prevention, *National Immunization Survey 2006*.

Benefits of Immunizations

Immunizations are often described as one of the most important public health achievements of the 20th century.[94] Routine childhood immunizations are estimated to prevent 10.5 million cases of illness and 33,000 deaths for one birth cohort in the U.S. Supporters of vaccines and immunization requirements believe that vaccines protect not only those receiving the vaccines, but also the entire community, because they protect those who are not vaccinated by decreasing their chances of encountering the disease. This is known as "herd immunity" and is especially important for those who cannot be immunized, such as those who are too young to be effectively vaccinated for certain diseases, those who cannot be vaccinated for medical reasons, and those for whom the vaccine proves ineffective (i.e., those who do not develop an adequate immunity to the disease). In order to achieve herd immunity, approximately 95 percent of the people in a community must have received a vaccine.[95]

Despite the benefits of immunization, there are still barriers to achieving higher immunization rates. As identified by the National Vaccine Advisory Committee (NVAC), the most significant barriers are those related to poverty or markers of poverty such as residence in public housing, racial and ethnic barriers, lower education rates, and the prevalence of single mothers. Other factors include being uninsured or underinsured and parents' lack of knowledge about when vaccines are due. In order to raise vaccination levels, DSHS uses the following strategies: promoting the concept of the medical home; promoting the use of the statewide immunization registry, ImmTrac;

[94] Lani K. Ackerman, *Update on Immunizations in Children and Adolescents*, American Family Physician, Vol. 77, No. 11, 2008, p. 1561-1568.
[95] Council of State Government's Healthy States Initiative, *Immunization Tool Kit*, August 2007.

expanding provider education; promoting the use of reminder/recall systems for providers; increasing public and parent education; and developing public/private collaborations. Examples of such collaborations include the Federal Vaccines for Children Program (VFC) and the Texas Immunization Stakeholder Working Group.[96] The VFC program was created in 1993 to provide free vaccinations to children under the age of 18 who are uninsured, Medicaid-eligible, Native American or Alaskan Native, or underinsured and receive vaccines in federally-qualified health centers (FQHC) or rural health clinics. The Texas Immunization Stakeholders Working Group provides a forum for stakeholders to share ideas, perspectives, best practices, and resources to enhance efforts to raise vaccine coverage levels in Texas. Recently, the group has focused on five main topic areas: provider recruitment and engagement of specialty societies, provider education, public education, alternative vaccination sites, and non-comprehensive visits.

Immunization Costs and Financing

Using the recommended seven-vaccine childhood immunization schedule saves $9.9 billion in direct medical costs and $43.3 billion in societal costs annually. From 1995 to 2004, the chickenpox vaccine saved $100 million in hospital care costs alone, not including reductions in the costs of doctors visits, prescription drugs, or lost work or school time. The influenza vaccine saves $182 in medical costs per vaccinated person aged 65 and older and $14.71 for those between the ages of 18 and 64. Pneumonia vaccines save $8.87 in medical costs per vaccinated person aged 65 and older.

[96] Department of State Health Services, *Testimony before the Senate Committee on Health and Human Services,* Austin, Texas, August 26, 2008.

Immunization of 10 to 19 year olds against whooping cough saves $1.6 billion in direct and indirect costs over 10 years. Vaccinating adolescents against meningitis saves $18 million in direct costs and $50 million in lost productivity.[97]

The federal government finances almost half (49 percent) of childhood vaccines financed either through the VFC program (43 percent) or Section 317 Immunization grants. Section 317 grants are awarded to state and local health departments to support mass immunization campaigns. States finance six percent of childhood vaccines and 45 percent are funded through the private sector. Although more than half of U.S. residents have private health insurance, 11 million children and 59 million adults have private insurance that does not cover immunizations. Seventy-three percent of privately insured children have full coverage for immunizations. Texas, however, has a mandate that requires private insurers to cover immunizations for children up to age six. Additionally, co-payments and deductibles for immunizations are prohibited.[98]

Safety Concerns

Despite the benefits of immunizations, there are safety concerns surrounding childhood immunizations, and some parents of school-aged children opt out of vaccinating their children for these reasons. In the late 1990s and early 2000s, concerns emerged that mercury and thimerosal, a mercury-containing preservative included in some vaccines packaged in multi-dose vials in order to prevent bacterial contamination of vaccines,

[97] Lani K. Ackerman, *Update on Immunizations in Children and Adolescents*, American Family Physician, Vol. 77, No. 11, 2008, p. 1561-1568.
[98] Lani K. Ackerman, *Update on Immunizations in Children and Adolescents*, American Family Physician, Vol. 77, No. 11, 2008, p. 1561-1568.

were responsible for rising autism rates. However, only certain influenza vaccines currently contain mercury, and when thimerosal was removed from five vaccines, the autism rate continued to climb. In 2003, a committee of 15 CDC and NIH representatives analyzed available studies linking thimerosal to autism and found no scientific evidence supporting the link. The committee also noted that they did not consider a significant investment in studies of theoretical vaccine-autism links to be useful.[99] Thimerosal has been removed from all vaccines targeted toward children under the age of 6, but in 2004 the National Academies of Science Institute of Medicine (IOM) released a report, "Vaccines and Autism", which concluded that there is no scientific evidence to support a link between the two.[100] Cases involving potential injury from vaccines are brought before a special federal Vaccine Court under the provisions of the National Childhood Vaccine Injury Compensation Program, established in 1986. Under that program, individuals can file claims against the federal government rather than suing vaccine manufacturers or health care providers. The court is financed by a federal tax on vaccines and cases heard there require a much lower standard of proof than having to prove without any doubt that the vaccine directly caused the injury. In March 2008, the court awarded damages to a 9 year-old girl and her family in a case in which her parents claimed that vaccines had contributed to her autism by exacerbating an existing mitochondrial disorder.[101] Additionally, two to three percent of school-aged children's

[99] *How Safe are Vaccines?*, Time, June 2, 2008.
[100] Lani K. Ackerman, *Update on Immunizations in Children and Adolescents*, American Family Physician, Vol. 77, No. 11, 2008, p. 1561-1568.
[101] *More Vaccine-Autism Link Cases Heard By US Court*, Medical News Today, May 13, 2008.

parents opt out of vaccines for religious or philosophical reasons. Twenty states, including Texas, allow philosophical exemptions for required school vaccinations.[102]

Availability of Vaccines

Routine childhood vaccines are made available to all children in Texas, and DSHS relies heavily on private providers to ensure their patients receive needed immunizations on schedule. A safety-net program exists for adults who are not insured or whose insurance does not cover immunizations.

Current Immunization Policies

With few exceptions, Title 25 of the Texas Administrative Code requires that children receive certain vaccines before entering kindergarten. These vaccines include five doses of a vaccine containing diphtheria-tetanus-pertussis, four doses of polio vaccine, two doses of MMR (Measles-mumps-rubella) vaccine, one dose of varicella, and two doses of Hepatitis B to be administered before the child enters kindergarten. The 80th Legislature enacted House Bill 3184, which requires DSHS to work toward increasing immunization awareness among parents of children in child care facilities and to increase participation in the state's early childhood vaccination program.[103] The bill authorized DSHS to publish this information on its website about the benefits of annual immunization against influenza for children aged six months to five years.

[102] *How Safe are Vaccines?*, Time, June 2, 2008.
[103] Texas House of Representatives, House Bill 3184, 80th Legislature, 2007.

Proposed Changes to Immunization Policies

DSHS rules that specify immunization requirements for school entry are currently undergoing the required four-year review. Based on CDC and the Advisory Committee on Immunization Practices (ACIP) recommendations, DSHS added a new meningococcal vaccine requirement for 7th graders beginning with the 2009-2010 school year. Stakeholders, including the Texas Medical Association, the Texas Pediatric Society, school nurses, and the Meningitis Angels (an advocacy group) have expressed support for the meningococcal vaccine for adolescents.

The CDC estimates that 1,400 to 2,800 cases of meningococcal disease occur in the U.S. annually. The disease is transmitted from person-to-person through direct contact with nose and throat secretions. An infected person can transmit the disease by coughing or sneezing directly into the face of others, kissing a person on the mouth, or sharing a glass or cup. Ten to 14 percent of those diagnosed with meningococcal disease die. Eleven to 19 percent of survivors have life-long disabilities such as neurological disability, limb loss, or hearing loss. However, in January 2005, a new meningococcal vaccine (MCV4) was licensed for use among individuals ages 11-55. In June 2007, the recommendation was revised to include routine vaccination of all 11-18 year olds with one MCV4 dose at the 11-12 year old healthcare visit. Most children in this age group are in 7th grade. The vaccine is a one-dose series, and currently costs $68 per dose. Additionally, DSHS has added doses and enhanced the requirements for varciella, MMR, and Hepatitis A. The

rule changes were approved, will be adopted in late 2008 or early 2009, and will be effective for the 2009-10 school year.[104]

Conclusion

Obesity, caused by poor nutrition and physical inactivity, and tobacco use are responsible for countless cases of preventable deaths, chronic illnesses, and rising health care costs in Texas. Healthier personal choices, better preventative care, and more conscientious disease management are necessary to reverse these trends. Although much has been done legislatively in the past to remedy these issues, there is still progress to be made. Encouraging increased physical activity, providing nutritional education, and improving nutrition are critical, especially among children, making school-based initiatives particularly appealing. Promotion of worksite wellness and encouraging community-based approaches are effective ways to reach the adult population. Immunizations have been extremely effective in eradicating formerly common childhood diseases and in enhancing the health of society in general. Although Texas currently has a relatively high immunization rate among children, more can be done to improve this number, such as ensuring that providers are fully reimbursed for the cost of vaccines.

Recommendations

1. **Enhance the guidelines for School Health Advisory Councils (SHACs) by requiring that a parent be Chair or co-Chair; that the SHAC meet at least**

[104] Comment of Texas Department of State Health Services, public meeting on Texas Immunization Requirements, Austin, Texas, May 12, 2008.

four times per year; and that the SHAC reports its recommendations and progress directly to the school board at least once per year.

Rationale: Every school district is required to have a SHAC. However, in practice, many only meet once per year, parent involvement is limited, and there is little accountability to the local school board. Specifying meeting and reporting requirements would increase the efficacy and accountability of SHACs.

2. **Promote and fund nutrition education in early childhood education environments.**

   Rationale: Good habits are formed early in life, and it is critical that young children have the opportunity to develop healthy eating habits as soon as possible.

3. **Create a Healthy Food Retail Study Group to investigate the lack of access to fresh, healthy foods in certain areas of Texas.**

   Rationale: Access to fresh produce and other healthy foods is restricted in certain areas of the state, particularly those with high incidence of poverty. In these areas, barriers to accessing healthy foods, including a lack of transportation, further compound the problem. A Healthy Food Retail Study Group would examine this issue and make recommendations for the creation of a statewide program to bring fresh food retailers to underserved parts of the state.

4. **Establish suggested criteria for new school construction that promotes physical education.**

   Rationale: Providing school districts with suggested criteria for the inclusion of areas for physical education instruction and open play in new school buildings would ensure that fitness and physical activity are incorporated throughout the school day.

5. **Fund Coordinated School Health.**

   Rationale: Coordinated School Health is currently not fully funded. The Texas Education Agency has requested that funding be provided to hire additional staff to implement comprehensive nutrition and fitness programs as well as to facilitate fitness assessments screenings in schools.

6. **Provide incentives for employers to encourage them to establish worksite wellness programs that include nutrition, physical activity, tobacco cessation counseling, healthy vending machine options, subsidized health club memberships, and insurance discounts for preventative services.**

   Rationale: Tax credits or deductions would make it more attractive for businesses to establish worksite wellness programs.

7. **Collect data on Physical Education class sizes and teacher certifications.**

   Rationale: This data represents an important component of Coordinated School Health and school-based child health programs in general, and there is currently no central source of data relating to PE class sizes or the prevalence of certified PE teachers in Texas schools.

8. **Promote community development and revitalization of sidewalks, bike paths, and lighting in order to promote walking and biking to school or work.**

   Rationale: Neglected and dilapidated sidewalks, bike paths, and outdoor activity areas in communities discourage walking and biking to school and promote sedentary lifestyles. Improved infrastructure will increase physical activity in communities.

9. **Provide guidance to businesses on worksite wellness program design and implementation.**

   Rationale: Obesity and other preventable chronic conditions cost Texas businesses more in health care costs and lost productivity each year. Many small businesses may be eager to improve the health of their employees but lack the resources to develop a plan for a worksite wellness initiative. The Department of State Health Services could assist by providing guidance regarding the design and implementation of employee wellness plans, tracking progress, and providing information relating to actions allowable under federal and state laws.

10. Codify the existing Texas School Nutrition Policy into law.

Rationale: Texas School Nutrition Policy is currently not in statute. Codifying this policy into state law would ensure that changes could not be easily made to the policy and that all Texas school districts are held accountable to the same nutritional standards.

11. Develop a public education campaign on diabetes management.

Rationale: Most diabetes awareness initiatives are targeted toward health care providers and might not reach those without a medical home. Additionally, many people do not know that diabetes is a preventable, treatable disease or how to prevent themselves from developing it.

12. Encourage high schools to identify or establish community-based fitness activities for students to participate in outside of normal school hours.

Rationale: Challenges in requiring a certain amount of physical activity per day or week for high school students include required academic proficiency testing, advanced placement courses, college preparation, and other required coursework. Collaborations with the private sector may prove to be an efficient and practical way to meet the goal of ensuring adequate physical activity among high school students.

13. Support public sector wellness programs as models for the private sector.

Rationale: Prior to and since the adoption of the State Employee Wellness Program, (Senate Bill 1297, 80th Legislature) Texas government agencies have successfully implemented wellness programs.

14. Ensure that health insurance plans reimburse providers for the cost of purchasing vaccines.

Rationale: Immunizations are an effective and relatively inexpensive way to improve general public health in Texas. However, in some cases, providers are not being fully reimbursed for the cost of purchasing vaccines. Ensuring that providers who pay competitive but reasonable price for vaccines are fully covered for the cost of purchasing vaccines will encourage them to purchase more courses and enable them to immunize more of their patients against easily-preventable diseases.

Charge # 8 Nursing Home And Home Care Rates and Best Practices

Study the effectiveness and efficiency of nursing homes and home-based solutions/home care in Texas, and make recommendations to improve nursing homes and their funding. Identify and study successful nursing home funding models established by other states. Consider ways to fund infrastructure for nursing and therapists and home care. Examine the possibility of an incentive-based "Pay-for-performance" rate plan for nursing facilities and consider factors that it could be based on, taking into account similar plans implemented in other states. Make recommendations on how best to use Medicaid to fund skilled nursing and home health care in Texas. Explore options for improving graduation rates for nurses in Texas.

Background

Many of today's senior and disabled citizens wish to remain independent and live in their own homes while receiving support services through home care agencies. When these services cannot be provided in the home, many seniors and disabled turn to assisted living or nursing home facilities. While the demand for support services has grown, so has the cost of providing these services. Home health care and nursing home care services are paid for by Medicaid, Medicare, or through private pay. In 2005, Medicaid spent $94.5 billion nationally on long-term care services.[1] Consumers of long term care services demand high quality regardless of who is funding or providing those services.

[1] AARP, *Across the States Profiles of Long-Term Care AND Independent Living,* p 10. Available: http://assets.aarp.org/rgcenter/health/d18763_2006_ats.pdf. Accessed: July 2008.

The scope of this report is limited to reviewing nursing home and non-Intermediate Care Facilities for the Mentally Retarded (non-ICF/MR) home health care programs. Among these programs, Medicaid long term care services are divided into two categories: entitlement services and waiver services. Entitlement services are those which the state must provide to anyone who is eligible and seeks care. Examples include nursing facility care, primary home care, community attendant services, day activity and health services. Medicaid 1915(c) waiver services are subject to limits according to state appropriated levels and include community based alternatives, a consolidated waiver program and a medically dependent children's program.

Home Health Care

According to the Department of Aging and Disability Services (DADS), nearly one-third of seniors living at home need assistance with personal care,[2] including hygiene, bathing, and grooming. Relative caregivers often assist with seniors' personal care needs. However, when seniors need further assistance, they often turn to home and community support service agencies (HCSSAs), which provide home health care services ranging from non-medical personal care services to skilled nursing services that may include preventative, acute, sub-acute, rehabilitative, and long-term care. Consumers who use these agencies often avoid institutionalization and/or hospitalization, which can cost more to the consumer and the state. DADS regulates all home health agencies regardless of the source of funding. As of June 2008, there were 3,754 HCSSA parent agencies, 708

[2] Department of Aging and Disability Services, *Testimony before the House Committee on Human Services*, January 2008.

branch agencies, and 131 alternate delivery sites (i.e., branches of hospice agencies) in Texas.

Nursing Home Care

Nursing home facilities provide twenty-four hour care for persons needing total medical, nursing, and psychological services.[3] Residency can either be long-term or short-term, depending on the individual's needs. In light of the many community options, today's nursing home population is older with a higher acuity.[4] As of February 2008, there were 1,179 nursing home facilities in Texas. Of that total, 1,081 were Medicaid certified, 1,013 were dually certified for Medicare/Medicaid and 68 were Medicare certified only. As of November 2007, the capacity rate for Medicaid certified beds was 74.8 percent.[5] On average, 57,217 persons receive Medicaid-funded nursing facility services at a cost of $2,564.75 per month.[6] Eighty percent of today's seniors who reside in nursing facilities rely on Medicare or Medicaid to pay for their care.[7] These numbers are significant because the payer rates are quite different.

Texas' Rate Methodology

The Texas Health and Human Services Commission (HHSC) developed a complex nursing facility cost methodology in order to determine the rate that HHSC would recommend to the legislature. This rate methodology is uniform across the state and is

[3] Adelaide Horn, Department of Aging and Disability Services, *Testimony before the Senate Committee on Health and Human Services*, March 26, 2008.
[4] Tim Graves, Texas Health Care Association, *Testimony before the Senate Committee on Health and Human Services*, March 26, 2008.
[5] *Ibid.*
[6] Adelaide Horn, Department of Aging and Disability Services, *Testimony before the Senate Committee on Health and Human Services*, March 26, 2008.
[7] *Ibid.*

determined by the level of service (i.e., case-mix).[8] HHSC uses audited cost reports and cost inflation indicators to recommend rates to the legislature. The methodology's rate components include:

- direct care staff cost per diem - compensation for nurses and nurse aides;
- other residential care per diem - social workers, activities staff, therapists pharmacists, medical equipment, supplies, laundry/housekeeping;
- dietary care - cost of dietary staff, food, nutritional therapy supplements, dietary equipment, and dietary supplies;
- general and administrative - administrative and maintenance staff, legal and other consulting fees, property equipment and repair, office supplies, insurance, property taxes, and transportation;
- fixed capital asset use fee - bricks and mortar;
- liability add-on - for those carrying liability insurance; and
- direct care staff enhancement. [9]

Some of these components are adjusted for case-mix according to residents' service needs or acuity. In September 2008, the state transitioned from the 11-group Texas Index for Level of Effort (TILE) case mix classification to the 34-group federal Resource Utilization Groups (RUGS) case mix system. The federal Centers for Medicare and Medicaid Services (CMS) uses the RUGS system, which depicts the case-mix of residents more accurately and creates less paperwork for providers. For further details on rate components, refer to the HHSC's testimony before the Senate Committee on Health

[8] Pam McDonald, Health and Human Services Commission, *Testimony before the Senate Committee on Health and Human Services*, March 26, 2008.
[9] *Ibid.*

and Human Services.[10] Although HHSC uses the above rate methodology to recommend appropriations, the legislature has not fully funded HHSC's recommendations for some years. If appropriations are not sufficient to fully fund the rate generated by the HHSC's methodology, any increased appropriations are distributed proportionally across all cost centers based on each cost center's ration of costs as reported on the most recently audited cost report to existing payment rates.[11] Nursing home advocates have long voiced their support for significant Medicaid rate increases based on their belief that quality improvements are directly correlated to funding stability.[12] According to HHSC, the weighted average nursing facility rate as of January 2008 equals $108.88 per day of service.

Historical Nursing Facility Costs/Methodology Rate and Funded Rates in 2008 Dollars[13]

	SFY04-05	SFY 9/1/05-12/31/05	SFY 1/1/06-8/31/07	SFY08
Cost/Methodology Rate 2008 Dollars	$112.02	$119.75	$119.75	$119.99
Appropriated Rate in 2008 Dollars	$101.22	$97.67	$106.91	$106.59

Like the HHSC nursing facility cost methodology, the home care waiver rate (CBA) methodology is also statewide, rebased every two years, and developed from cost reports.[14] HHSC determines the weighted median cost for each service, then multiplies that number by 1.004.[15] As with nursing home rates, the legislature determines the amount of the recommended HHSC home care rate.

[10] Pam McDonald, Health and Human Services Commission, *Testimony before the Senate Committee on Health and Human Services*, March 26, 2008.
[11] *Ibid.*
[12] Tim Graves, Texas Health Care Association, *Testimony before the Senate Committee on Health and Human Services*, March 2008.
[13] Pam McDonald, Health and Human Services Commission, *Testimony before the Senate Committee on Health and Human Services*, March 26, 2008.
[14] *Ibid.*
[15] *Ibid.*

Historical CBA/CWP Costs/Methodology Rate and Funded in 2008 Dollars[16]

CBA/CWP Rates 2008 Dollars	Funded Rate			Cost/Methodology Rate		
	SFY04-05	SFY06-07	SFY08	SFY04-05	SFY06-07	SFY08
Personal Assistance Services per hour**	$10.78	$10.30	$10.46	$11.46	$10.75	$11.37
Registered Nurse (RN) - per hour	$36.70	$35.08	$43.39	$38.08	$40.41	$50.62
Licensed Vocational nurse (LVN)- Per hour	$27.50	$26.29	$29.69	$30.78	$31.64	$29.69
Physical Therapy (PT) - per hour	$70.87	$67.74	$66.88	$77.65	$67.74	$69.72
Occupational Therapy(OT)- per hour	$67.60	$64.62	$63.53	$72.51	$64.62	$63.06
Speech Pathology (SP) per hour	$66.45	$63.52	$62.44	$77.11	$63.52	$61.48
In-Home Respite Care- per day	$250.66	$239.59	$238.60	$345.48	$258.46	$252.34
Pre-enrolment Assessment - one time	$141.86	$135.60	$157.21	$151.97	$152.17	$157.21
* Excluding Adult foster care and Respite						
** Does not include enhancements for CBA						

Texas' Ranking in National Healthcare Quality Measures

The U.S. Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ) generates an annual *National Healthcare Quality Report* (NHQR). This report examines both national and state level data in areas including home health care and nursing home care and facilitates comparisons between individual states and national averages on specific quality measures. Based on this data, the 2007 NHQR provides an overall snapshot of each state's level of care in both the home health and nursing home markets. These state snapshots are available online via the AHRQ website.[17]

[16] Pam McDonald, Health and Human Services Commission, *Testimony before the Senate Committee on Health and Human Services*, March 26, 2008.
[17] 2007 *National Healthcare Quality Report.* Available: http://www.ahrq.gov/qual/qrdr07.htm. Accessed: July 2008.

The basis for the home health care quality measures in the NHQR is the Outcome and Assessment Information Set (OASIS), a standardized data collection instrument developed by CMS. The OASIS data, and consequently the NHQR report, only reflect care given to Medicare and Medicaid beneficiaries. Home health care agencies report this data to state agencies, which in turn report the data to CMS. The data reported to CMS and used in the 2007 NHQR reflect measures for 2006. Based on this data, the AHRQ determined that Texas' overall level of quality of care in the home health market is in the very weak range compared to all other states, meaning that the majority of incorporated measures reported in 2006 were below the national average. This rating represents a decrease in the level of quality of care from the 2005 data, which rated Texas' home health care quality in the weak range. Selected home health care measures used in the Texas state snapshot are shown below:

Home Health Care Quality Measures from OASIS Data[1]

Full NHQR Measure Title	State Performance	Most Recent Data Year	State Rate	All-State Average	Regional Average	Baseline Year	Average Annual Change	Direction of Change
There are no measures for Texas recorded as "better than average"								
Percent of home health care patients who get better at taking their medicines correctly (by mouth)	Average	2006	39.6	38.6	40.1	2005	2.1%	Improved
Percent of home health care patients who had to be admitted to the hospital	Worse than Average	2006	36.8	29.7	37.5	2005	3.4%	Worsened

The nursing home quality measures in the NHQR are based on data that nursing home facility personnel report to CMS as part of the Minimum Data Set (MDS) assessment

[1] U.S. Department of Health and Human Services, *AHRQ State Snapshots*. Available: http://statesnapshots.ahrq.gov/snaps07/index.jsp?menuId=1&state=TX. Accessed: June 2008.

tool. This data reflects care given to all residents who reside in Medicare or Medicaid certified nursing homes. The data reported to CMS and used in the 2007 NHQR likewise reflects measures for 2006. Based on this data, the AHRQ determined that Texas' overall level of quality of care in the nursing home market is in the strong range compared to all other states, consistent with Texas' previous reports. Selected nursing home care measures used in the Texas state snapshot are shown below:

Nursing Home Care Quality Measures from MDS Data[2]

Full NHQR Measure Title	State Performance	Most Recent Data Year	State Rate	All-State Average	Regional Average	Baseline Year	Average Annual Change	Direction of Change
Percent of short-stay nursing home residents with pressure sores	Better than Average	2006	14.5	16.1	15.1	2002	-5.0%	Improved
Percent of long-stay nursing home residents who have moderate to severe pain	Average	2006	4.2	4.1	4.4	2002	-18.0%	Improved
Percent of long-stay nursing home residents who spent most of their time in bed or in a chair	Worse than Average	2006	6	2.7	6.3	2002	-3.4%	Improved

Successful Funding Models

Federal Medicare Pay-for-Performance

At the federal level, the current Medicare fixed-rate reimbursement system pays health care providers for services regardless of outcome measures. Increasing costs have led CMS to evaluate how pay-for-performance strategies may be applied in its reimbursement procedures in order to help drive down these costs. CMS demonstration projects mandated by the Medicare Prescription Drug, Improvement, and Modernization

[2] U.S. Department of Health and Human Services, *AHRQ State Snapshots*. Available: http://statesnapshots.ahrq.gov/snaps07/index.jsp?menuId=1&state=TX. Accessed: June 2008.

Act of 2003 (MMA) are currently underway to evaluate pay-for-performance in both the nursing home and home health care markets.

The Nursing Home Value Based Purchasing Demonstration Program[3] is scheduled to begin its three year demonstration in Fall 2008. CMS is in the process of selecting final demonstration sites and has indicated that the demonstration will include both free-standing and hospital based nursing homes that serve Medicare Parts A and B beneficiaries. CMS will conduct annual evaluations of participating nursing homes and will provide incentive payments to facilities based on their quality measure outcomes. The demonstration will be budget-neutral and quality measures will be taken in the following four areas: staffing, appropriate hospitalizations, MDS outcomes, and survey deficiencies.

The Home Health Pay-for-performance Demonstration[4] began in January 2008 and will continue through December 2009. Medicare certified demonstration sites were selected in five states and include sites with varying agency sizes, ownership structures, and urban and rural locations. CMS will provide incentive payments to reward agencies for making significant improvements or maintaining high levels of quality or care. These incentive

[3] Centers for Medicare and Medicaid Services, *Nursing Home Value Based Purchasing Demonstration Program*. Available: *http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=dual,%20keyword&filterValue=performance&filterByDID=0&sortByDID=3&sortOrder=descending&itemID=CMS1198946&intNumPerPage=10*. Accessed: July 2008.

[4] Centers for Medicare and Medicaid Services, *Home Health Pay-for-performance Demonstration.* Available: *http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1189406&intNumPerPage=10*. Accessed: July 2008.

payments are limited to Medicare Fee-For-Service (FFS) episodes, and agency outcome measures do not reflect care given to non-Medicare patients.

State Medicaid Pay-for-Performance

State Medicaid programs are also moving toward pay-for-performance programs that incentivize nursing home providers to improve quality. This movement toward value-based purchasing attempts to increase the transparency and accountability of state funds. Six states currently have pay-for-performance programs in their Medicaid reimbursement for nursing homes: Georgia, Iowa, Kansas, Minnesota, Ohio and Oklahoma.[5] Some states' pay-for-performance programs are mandatory, requiring participation by all nursing homes in the state, while other states' programs are permissive. A successful state pay-for-performance program must measure the correct indicators for quality. State Medicaid directors generally provide favorable reports regarding their pay-for-performance programs, stating that these programs improve quality.[6]

In 2007, Georgia enacted the Georgia Nursing Home Quality Initiative, a voluntary pay-for-performance program for nursing home facilities based on eight performance measures, including consumer and staff satisfaction. Participating facilities that satisfy these performance measures receive an enhanced Medicaid rate. Georgia's pay-for-performance program participation rate is over 95%.

[5] My InnerView, *Value-Based Purchasing in Nursing Home*, p.3. November 2007.
[6] Hartman, Thomas and Kuhmerker, Kathryn**,** *PAY-FOR-PERFORMANCE In State Medicaid Programs: A Survey of State Medicaid Directors and Programs.* April 2007. Available: http://www.commonwealthfund.org/usr_doc/Kuhmerker_PAY-FOR-PERFORMANCEstateMedicaidprogs_1018.pdf?section=4039. Accessed: September 2008.

Oklahoma has a similar pay-for-performance program but couples it with a website that lists nursing facilities' performance and assists consumers in selecting a nursing facility. The website includes information about quality of care and employee, resident and family satisfaction, and regulatory compliance data.[7]

Other Quality Initiatives

Federal Background Check Demonstration Project

A 1996 amendment to the Social Security Act (SSA) effectively prohibited long term care facilities that participate in federal health programs from employing persons convicted of crimes relating to patient abuse, controlled substances, or health care fraud.[8] However, the SSA's criteria for conducting criminal background checks were minimal, leading to the call in the MMA to develop a more streamlined, comprehensive, and cost-effective program to carry out criminal background checks in order to ensure the safety of patients in long term care facilities nationwide.

Section 307 of the MMA[9] charged CMS with administering a demonstration program to explore the feasibility of screening prospective employees in long term care facilities. The demonstration program began in January 2005 and concluded in September 2007, with a program evaluation expected in Fall 2008. Seven states were selected to participate in the demonstration program. These states were required to implement a criminal background check pilot program that would supplement existing federal and

[7] Oklahoma Health Care Authority, news release, *New state website helps Oklahomans choose nursing facilities*, April 2008.
[8] United States Code, Chapter 42, §1320a-7(a) .
[9] Centers for Medicare and Medicaid Services, *Background Check Pilot Program*. Available: http://www.cms.hhs.gov/SurveyCertificationGenInfo/04_BackgroundCheck.asp. Accessed: July 2008.

state law by integrating several steps into a single process. Participating states were required to screen prospective employees using all available state databases and registries which may contain disqualifying information. CMS also partnered with the Department of Justice to enable participating states to conduct federal criminal background checks through the Federal Bureau of Investigation's Integrated Automated Fingerprint Identification System.

Other State Background Check Programs

At the state level, background check programs for nursing home facilities have been implemented to varying degrees. Currently, 41 states require criminal background checks. Some states use only a name-based criminal background check while others require fingerprint checks in addition to name-based criminal background checks.

Prior to the demonstration program, Michigan, one of the pilot states, already had provisions for criminal background checks. However, this program enabled Michigan to link databases, creating a comprehensive, statewide system to search databases such as the state's sex offender registry and nurse aide registry, all with a single search.[10]

Texas Background Checks

In Texas, DADS requires the Texas Department of Public Safety (DPS) to conduct criminal background checks when any of the following entities apply for licensure: HCSSAs, nursing facilities, ICFs/MR, adult day care facilities, and assisted living

[10] Michigan Workforce, *Background Check Program: Legal Guide*. Available: http://www.miltcpartnership.org/Documents/LegalGuide.pdf. Accessed: July 2008.

facilities. When these entities apply for licensure, DPS conducts a name-based criminal background check on certain agency directors (e.g., owners, administrators, CFOs, managers) using data from all 50 states.[11]

DADS may deny any of these entities' licensure based on the results of a criminal background check. However, the standards governing licensure denial vary depending on the entity applying for a license. For example, DADS may deny a nursing facility's licensure if a criminal background check on any controlling person reveals a state or federal criminal conviction within the five year period preceding the application and the conviction provides a penalty of incarceration. Similarly, DADS may deny licensure of ICFs/MR, adult day care facilities, and assisted living facilities if a criminal background check on any controlling person reveals a state or federal criminal conviction within the two year period preceding the application and the conviction provides a penalty of incarceration. Finally, DADS may deny an HCSSA's licensure if a criminal background check on any controlling person reveals certain specified convictions, irrespective of when they occurred.

Historically, Texas has required name-based criminal background checks for a number of occupations. However, there has been a recent push to require fingerprint checks in addition to name-based criminal background checks in order to ensure the safety of patients in long term care facilities throughout Texas and to combat fraud by ensuring

[11] Department of Aging and Disability Services, *Criminal Background Checks in Entities Licensed by DADS,* p. 2. June 2008.

that persons convicted of crimes relating to patient abuse, controlled substances, or health care fraud are not employed in direct care occupations.

CMS Quality Initiatives

Within the last decade, CMS has attempted to transition from operating as a reactive organization to a proactive organization, with the goal of continuously improving quality for its beneficiaries. Among CMS' top priorities is to develop a culture of improvement in which new ideas and practices are developed, tested, then adopted if proven successful. Examples of this transition were seen in 2001 with U.S. Health and Human Services Secretary Thompson's introduction of CMS' *Quality Initiative*,[12] and later with the numerous demonstration projects called for in the MMA.

The 2002 Nursing Home Quality Initiative[13] was the first in a series of CMS quality improvement initiatives. The goal of this initiative is to create a standardized evaluation system for all Medicare and Medicaid certified nursing homes in the U.S. and, with the use of this system's data, continuously improve nursing home care. In order to ensure a comprehensive assessment, CMS developed a nursing home evaluation system that relies on data gathered from two different sources. The first data source includes information that nursing homes routinely collect and report using CMS' MDS assessment tool. The second data source includes information that state survey and certification agencies collect and report using the Online Survey, Certification, and Reporting System

[12]Friesen, Shawn, *Paying for Quality: Making Policy and Practice Work for Patients* [Electronic version], 2005. *Bulletin of the American College of Surgeons, 90*(11).
[13] U.S. Department of Health and Human Services, *Nursing Home Quality Initiatives*. Available: http://www.cms.hhs.gov/NursingHomeQualityInits. Accessed: July 2008.

(OSCAR). OSCAR includes annual surveys of family members, nursing home residents and nursing home staff.

A key component of CMS' drive for quality improvement involves communicating findings and being accountable to the public. To achieve this goal, CMS created a "Nursing Home Compare" website equipped with a number of resources to help consumers evaluate their options.[14] Consumers who visit the website may access a searchable database of Medicare and Medicaid certified nursing homes and annual results of surveys evaluating these nursing homes. Using MDS quality measurement outcomes, consumers can also compare specific nursing homes to one another or to state and national averages.

The Nursing Home Quality Initiative was designed to be a collaborative effort between public and private organizations. To accomplish its goals of improving nursing home performance and communicating information to stakeholders, CMS has contracted with private organizations in each state, which are deemed Medicare Quality Improvement Organizations (QIOs). QIOs help CMS reach these goals by working with nursing homes and community stakeholders. QIOs also assist nursing homes in understanding CMS' quality measures, analyzing the nursing homes' strengths and weaknesses, and helping them develop quality improvement systems designed to enhance their performance. They also assist community stakeholders by providing information to advocacy groups, community groups, health care organizations, local businesses, and media outlets to

[14] U.S. Department of Health and Human Service, *Nursing Home Compare*. Available: http://www.medicare.gov/NHcompare/. Accessed: July 2008.

familiarize the public with the Nursing Home Quality Initiative and the resources now available because of this initiative.

In 2003, the Home Health Quality Initiative[15] was enacted as the next step in CMS' quality improvement initiative. Pursuant to this initiative, home health care service is now available for Medicare Part A beneficiaries as long as the agency delivering the service is a Medicare certified agency. Currently, there are more than 9,000 Medicare certified agencies in the U.S., all of which are required to submit periodic client assessments using OASIS.

To achieve its goal of communicating information to the public, CMS created the consumer-oriented "Home Health Compare" website.[16] Consumers who visit the website can compare Medicare certified home health agencies based on selected OASIS measures and determine what services each agency offers. The website includes detailed explanations of each measurement, including how it is collected and its significance in determining agency quality, and explains patient rights and Medicare home health insurance coverage information.

As part of the Home Health Quality Initiative, CMS contracted with QIOs in each state to elevate public awareness of the initiative, inform stakeholders about what information is available and how to obtain it, and help implement quality improvement practices

[15] Centers for Medicare and Medicaid Services, *Home Health Quality Initiatives*. Available: http://www.cms.hhs.gov/homehealthQualityInits/. Accessed: July 2008.
[16] U.S. Department of Health and Human Services, *Home Health Compare*. Available: http://www.medicare.gov/HHcompare/. Accessed: July 2008.

within home health agencies. In carrying out these duties, QIOs are responsible for community outreach and help agencies use industry best practices to improve OASIS measurement outcomes.

Other States' Best Practices and Industry Best Practices

The National Clearinghouse on the Direct Care Workforce maintains a database of national and state-level best practice programs. This database includes profiles of programs implemented by service providers, educators, and worker and community organizations to improve the recruitment, training, and retention of personnel providing long term care services. In order to be included in the database, a program must be in place for at least six months and must provide some quantitative or qualitative evidence of its results.

Linking Employment, Abilities, and Potential (LEAP) of Cuyahoga County, Ohio is a program under which people with disabilities are trained to become personal care attendants (PCAs), home health aides, and state-tested nurse aides (STNAs). Program objectives include addressing the lack of trained, reliable, caring, and available direct care workers and expanding employment opportunities for people with disabilities. On average, the LEAP program trains 25 to 40 people are each year. Among the program's graduates, 80 - 85% are placed in direct care jobs where their retention rate is 90% after 90 days.

Wellspring Innovation Solutions, Inc. (Wellspring Program) is a nursing home-based initiative developed by an alliance of 11 nonprofit nursing homes located in Wisconsin.

The Wellspring Model's goals include improving the quality of care administered in nursing home facilities and reducing personnel turnover. In furtherance of these goals, participating nursing home facilities share information and resources, develop and implement personnel mentoring programs, and encourage facility personnel to participate in day-to-day decisions concerning residents' care.

Participating facilities "share" a general nurse practitioner (GNP) who administers training to nursing home facility personnel on industry best practices. The GNP schedules follow-up site visits three and six months after the initial training session. These site visits are intended to promote deployment of consistent, facilities-wide practices and reinforce new concepts. Also, in an effort to promote a sense of investment among personnel and reduce personnel turnover, participating facilities established personnel mentoring programs and encourage personnel to participate in day-to-day decisions concerning residents' care. Finally, in an effort to improve performance on annual inspections, enhance residents' quality of life, and decrease administration costs, participating facilities collaborate on strategies to resolve common challenges and share information concerning successful and unsuccessful past practices. Approximately 80 nursing home facilities throughout the U.S. currently participate in the Wellspring Program.

As stated previously in this report, the occupancy rate for nursing homes has steadily declined over the last decade while demand for home and community based services has increased. To address this market shift, a number of states, including Pennsylvania,

Minnesota, and New York, have implemented "rightsizing" programs for their nursing homes. These programs rebalance nursing home bed capacity by giving nursing homes incentives to consolidate, close or take a number of their Medicaid beds offline. States save Medicaid dollars by reducing the number of unused beds. Incentives to take these steps include financial and technical assistance implemented through either an enhanced Medicaid rate or grant. CMS approved certain states to receive federal-matching funds in order to help offset the costs to provide these incentives. Although results have been mixed with some of the early state adopters, some of the new programs show promise.

Texas' Quality Initiatives

Senate Bill 1, 76th Legislature, included staff and community care enhancements for nursing home providers. The staff enhancements were intended to incentivize nursing home providers to increase direct care staffing, wages and other benefits in nursing homes, while the community care enhancements were intended to increase community care attendants' compensation. Although these enhancement programs are voluntary, they are very popular, as evidenced by the high participation rate among providers. These enhancements include certain spending requirements which require community care providers to spend at least 90%, and nursing home facility providers to spend 85%, of their Medicaid revenues (including enhanced rate add-on) on attendant and direct care compensation.[17] In the event that nursing facility and community care providers do not satisfy their required staffing thresholds, the enhancement dollars are recouped and redistributed among providers that satisfy the spending and staffing requirements.

[17] Tom Seuhs, Health and Human Services Commission, *Testimony before the Senate Committee on Health and Human Services*, March 26, 2008.

As discussed in the Interim Charge # 1 report, DADS uses both the Quality Monitoring Program (QMP) and the Quality Reporting System (QRS) to improve outcomes in nursing facilities. The QMP helps nursing facilities improve care,[18] whereas the QRS provides consumers with information about specific long term care providers.

In addition, DADS administers annual quality reviews which include face to face interviews, clinical assessments, and mail-in surveys sent to randomly selected institutional and home-care consumers. [19]

Conclusion

Today's consumers of long term care services demand high quality from their providers. Recent innovative federal and state practices show great promise of fulfilling consumers' desires to remain independent while receiving the support services they need. Texas has the opportunity to learn from CMS' and other states' development of quality improvement programs and best practices. However, balancing the rising cost of providing long term care services with consumers' quality expectations will continue to pose a challenge.

Recommendations

1. **Require direct care workers and license holders in nursing facilities and home health agencies to submit to FBI fingerprint-based criminal background checks.**

[18] Adelaide Horn, Department Aging and Disability Services, *Testimony before the Senate Committee on Health and Human Services*, March 26, 2008.
[19] *Ibid.*

Rationale: Fingerprint-based criminal background checks prevent persons from falsifying their identity and helps further ensure the safety of those in their care.

2. **Create a statewide database that links registries such as the state sex offender registry, employee misconduct registry and nurse's aide registry. Require agencies to check this database periodically with existing employees.**

   Rationale: The State Auditor found weaknesses in DADS' policies regarding the nurse's aide registry and the employee misconduct registry. Linking databases and requiring periodic reviews would simplify background searches for direct care workers so that a single search would find results in all linked databases and would ensure that persons listed on the registries do not work with the frail and elderly.

3. **Create a statewide Pay-for-performance plan for nursing homes that rewards nursing home providers for reaching designated quality-of-care performance measures, which must include employee and consumer satisfaction surveys. Preferably, this plan would be accompanied by a Medicaid rate increase.**

   Rationale: This plan would create more accountability, promote transparency for consumers within the nursing home sector, and promote quality improvements and innovation.

4. **Require HHSC and DADS to study "right-sizing" and whether it is appropriate for Texas, and report their findings to the legislature.**

   Rationale: This study will help determine whether Texas can decrease Medicaid costs by reducing nursing home bed capacity to appropriate levels. Some states, including Minnesota and Pennsylvania, recently partnered with CMS to enact right-sizing programs and receive federal matching funds. Studying other states' programs should help determine whether right-sizing is appropriate for Texas.

5. **Direct DADS to develop job standards for direct care workers and develop a handbook.**

   Rationale: According to a report from the Stakeholder Committee on Recommendations for Direct Service Workforce, standardization of job descriptions and required training across the direct care workforce would clarify expectations.

Charge #9: Pandemic Flu

Study and address ethical issues surrounding the impact of a pandemic influenza in this state, particularly focusing on the following:

- *the availability of human and material resources;*
- *the benefits and burdens of mass vaccination plans;*
- *the involvement of private sector professional organizations and businesses in the state's pandemic influenza preparedness and response plans; and*
- *development and implementation of communication plans that will inform and prepare the public on risk reduction behaviors and local/state preparedness and response.*

Background

In contrast to seasonal influenza, which causes yearly epidemics of usually mild respiratory illness and results in 30,000 to 40,000 deaths in the United States annually, pandemic influenza is extremely unpredictable in terms of when an outbreak will occur, the scope of the disease, and how many deaths and illnesses will result. In order to be classified as a pandemic influenza, a new flu virus that has never infected human beings must emerge from animal reservoirs, the virus must infect humans, and it must be capable of spreading quickly through coughing and sneezing, person-to-person contact, or contact with contaminated surfaces.[1] In the past 100 years, there have been three pandemic influenza outbreaks: the Spanish flu in 1918, the Asian flu in 1957, and the Hong Kong

[1] National Governors Association Center for Best Practices, *Preparing for a Pandemic Influenza: A Primer for Governors and Senior State Officials*, 2006, p. 3-4.

flu in 1968. Although scientists have learned valuable lessons from these pandemics that can be applied to the study of future outbreaks, national experts are unable to reach a consensus on the anticipated severity or duration of the next pandemic influenza. However, most experts do consider such an event inevitable and some characterize it as a long overdue event. The rapid development of communications and technology since the last pandemic of 1968 also introduces new issues and opportunities in responding to the next pandemic.

Scientists and public health officials' estimates of the expected attack rate of the next pandemic influenza vary. Generally, estimates place the attack rate of an international pandemic at 25 to 50 percent, meaning that between 5 and 10 million Texans could become sick. Of these, an estimated 4 percent, or between 200,000 and 400,000 people, could require hospitalization. Projected fatality rates range from 1.5 to 5 percent, meaning that at the conservative attack rate of 25 percent, between 75,000 and 250,000 people might die as a result of the virus. At a 50 percent attack rate, between 150,000 and 500,000 people might die due to the virus.[2] Experts also expect that a second wave of influenza would occur three to nine months after the first outbreak, affecting an additional 5 percent of the population.

In addition to the fatalities and illnesses caused by a pandemic influenza, the typical functions of society would be disrupted during an outbreak as the virus spreads. Assuming that first responders and medical personnel would experience attack rates similar to those of the general population, there would be shortages of doctors, nurses,

[2] Department of State Health Services, *Pandemic Influenza Preparedness Plan*, October 2005, p. 14.

and emergency medical personnel to care for the sick, as well as first responders such as police and fire personnel. Other crucial professions, such as air traffic controllers, can be expected to be infected at the general population similar rates, which could bring air traffic to a halt. This could be especially detrimental in the transporting of life-saving vaccines and antivirals.[3] Businesses can be expected to experience high rates of employee absenteeism due to illness, which could disrupt their normal operations as well as their ability to provide products and services essential to the community. According to the Trust for America's Health, a severe pandemic would result in a loss of $55.1 billion to the state and a 5.6 percent drop in state Gross Domestic Product (GDP).[4]

Availability of Resources

Federal Funding

The U.S. Department of Health and Human Services (HHS) has provided the state with over $26 million in funding for pandemic planning and preparedness. In 2006, $325 million in federal funds was distributed to states in two allocations, with Texas receiving $21.3 million. In August 2007, a supplemental allocation of $75 million from HHS was distributed, with Texas receiving $4.77 million. The supplemental funding was designated for establishing or enhancing stockpiles of medical equipment and supplies, continuing development of state plans for maintenance and distribution of these resources, planning for and developing alternate care sites, and conducting medical surge exercises.

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[3] *Ibid*, p. 14.
[4] Trust for America's Health, *Healthier America Project*, 2008. Available: http://healthyamericans.org/state/index.php?StateID=TX.

Vaccines

Because the specific type of virus strain that causes a pandemic would not be known until it occurs, the production of vaccines could not begin until after the pandemic is underway. However, influenza vaccine experts believe that it is very likely that the next pandemic influenza will emerge from the H5N1 avian flu virus strain. The federal government has stockpiled 20 million 2-dose courses of a pre-pandemic vaccine in the Strategic National Stockpile (SNS), and GlaxoSmithKline received a European Union license to develop an avian flu pre-pandemic vaccine in May 2008. The pre-pandemic vaccine would use avian flu viruses already in circulation to provide early protection against pandemic influenza for those with the most critical need for protection, such as the medically fragile and first responders. Although experts estimate that it will take the next pandemic up to three months to reach the United States following international identification, the traditional method of developing a new influenza vaccine requires the use of eggs, which may take up to eight months to develop before it can be distributed to the general population. During the period between the emergence of a pandemic outbreak and the availability of the vaccine, public health experts recommend promoting seasonal influenza vaccines, which reduce illness and death resulting from a pandemic. The mass distribution of seasonal flu vaccines will also serve as a testing ground for the pandemic vaccination process.[5]

The federal government has established the goal of expanding U.S.-based production capacity to the point that it can generate 600 million doses of a pandemic influenza

[5] Baxter Bioscience Vaccines , *Testimony before the Senate Committee on Health and Human Services*, Austin, Texas, August 26, 2008.

vaccine within six months of the emergence of a pandemic virus, which allows for two doses per person. The target date to achieve this goal is 2011, and the federal government has reported that it is on schedule for meeting this deadline.[6] Accordingly, HHS awarded two contracts totaling $132.5 million to two manufacturers of egg-based vaccines to fund manufacturing facility renovations that will expand domestic production capacity by an estimated 16 percent.[7] The vaccine will be developed for the U.S. exclusively by Sanofi Pasteur until 2010. In the event of a pandemic, the availability of vaccines will depend upon vaccine technology, and more extensive licensing of the vaccine among domestic producers might reduce the likelihood of a shortage and the dependence on foreign vaccine sources.

In addition to the awarding of contracts to manufacturers of egg-based vaccines, HHS awarded $1 billion in contracts to pharmaceutical companies to develop cell-based technologies for making flu vaccines. These technologies would speed the process of vaccine development and expand capacity since cells can be frozen in advance and large volumes can be grown quickly. Cell-based methods are currently used for a number of other vaccines including polio, hepatitis A, and chickenpox.[8]

[6] U.S. Department of Health and Human Services, *Pandemic Planning Update V* , March 17, 2008, p. 8.
[7] U.S. Department of Health and Human Services, *HHS Awards Two Contracts to Expand Domestic Vaccine Manufacturing Capacity for a Potential Influenza Pandemic*, June 14, 2007, p. 1.
[8] Robert Roos, *U.S. Awards $1 Billion for Cell-Based Flu Vaccines,* Center for Infectious Disease Research and Policy, The University of Minnesota, May 4, 2006, p. 1-2.

Antivirals

Antivirals such as Tamiflu and Relenza can also be used during a pandemic to reduce the severity of influenza. Although they do not cure the illness or create immunity from the virus strain, antivirals typically reduce the length of the illness and the severity of the symptoms by about one-third. They also reduce the incidence of complications such as pneumonia, which is the most common cause of influenza death, by about two-thirds. In November 2005 the federal government set a national target of stockpiling 81 million antiviral treatment courses in the SNS by December 2008. As of March 17, 2008, the total SNS inventory amounted to about 50 million antiviral treatment courses. Texas' allocation of the national stockpile is 3,293,899 courses, which would be distributed upon near depletion of community or state antiviral supplies, or if antiviral manufacturers are unable to fill orders.[9] In addition to the courses of antivirals allocated from the SNS, the Department of State Health Services (DSHS) purchased 165,000 courses of antiviral medications, with 21,000 courses designated for the central office and 16,000 designated for each of the nine health service regions in the state. Additionally, the 80th Legislature appropriated $10 million in general revenue funds in 2007 to purchase 677,000 additional antiviral courses.

In an attempt to reduce waste and cut taxpayer expenditures on antiviral stockpiles, the federal government created the Shelf Life Extension Program (SLEP), which is operated by the U.S. Department of Defense in conjunction with the Food and Drug Administration (FDA). The purpose of the program is to defer antiviral replacement for

[9] Department of State Health Services, *Testimony before the Senate Committee on Health and Human Services,* (Austin, Texas, August 26, 2008).

date sensitive stockpiles by extending their useful life. The typical shelf-life of an antiviral drug is five to seven years. Under this program, participants in SLEP (including the SNS and all four branches of the military) submit samples of their stockpiles to the FDA, where they are tested to determine how long their shelf-lives can be extended. Results indicate that the shelf lives of a large percentage of the stockpiled antiviral samples tested have been extended from between 4 to 14 years, drastically reducing government spending on replacing expired antivirals and allowing larger volumes of antivirals to be stockpiled. In order reduce costs and increase stockpile levels, the National Academy of Sciences Institute of Medicine recommends that this program be expanded to include state governments.[10]

Human Resources

In the event of a pandemic, medical personnel would be stretched to their limits, as would the capacity of hospitals and other treatment sites. Currently, 187 of the 254 counties in Texas are designated as Primary Care Physician (PCP) shortage areas. The results of a survey of 235 Texas hospitals indicated that they routinely face a nursing shortage of approximately ten percent. It is estimated that by 2020, Texas hospitals will face a shortage of 70,000 nurses. The strain on manpower due to this shortage of health care professionals would be further exacerbated during a pandemic by the vulnerability of the healthcare workforce to be infected by the virus. Due to their first responder status and proximity to infected patients, it is estimated that during a pandemic, approximately 40

[10] Institute of Medicine of the National Academies, *Report Brief: Antivirals for Pandemic Influenza: Guidance on Developing a Distribution and Dispensing Program*, April 2008, p. 1-3.

percent of hospital employees would be sick.[11] Designated trauma hospitals in the state are especially vulnerable to both human and material resource shortages, as they are on diversion status an average of 30 percent of the time due to limited capacity and resources.

The large uninsured population in Texas frequently treats emergency rooms as a medical home because they do not have a PCP. This creates an overcrowding problem that would be intensified during a pandemic. Due to the shortage of medical personnel in a pandemic, hospital and clinic employees who are not licensed to administer vaccines or perform other tasks may be required to perform those functions, necessitating the use of alternate standards of care. Additionally, patient treatment might have to be administered in non-clinical settings, such as schools or community centers. During a pandemic, such medical shortages and overcrowding issues would likely require that ordinary citizens provide immediate basic needs for others. Public education materials and outreach would prepare citizens to take on these responsibilities.

Mass Vaccinations

The federal government would coordinate the distribution of both the pre-pandemic and the pandemic vaccine to states. Under the current version of the DSHS plan for pandemic preparedness, in the event of a pandemic influenza, DSHS would estimate the amount of vaccines needed for priority groups as defined by the Advisory Committee on Immunization Practices (ACIP) and the National Vaccine Advisory Committee (NVAC),

[11] Texas Hospital Association, *Testimony before the Senate Committee on Health and Human Services,* (Austin, Texas, August 26, 2008).

which are used in the U.S. Department of Health and Human Services Guidance on Allocating Vaccines.[12] Vaccines would be shipped directly to the state from the manufacturer. If vaccine supplies are not extremely scarce, mass vaccination clinics would likely be established to vaccinate targeted populations. During past pandemics, target groups have been determined by age and health conditions. However, because the high-risk groups of the next pandemic are still unknown, ACIP and NVAC have classified groups based on functions in society and will further define or broaden these categories in the event of an actual pandemic as the specifics of the outbreak become known. The target groups identified by ACIP and NVAC are as follows: individuals who protect homeland and national security, individuals who provide health care and community support services, individuals who maintain critical infrastructure, and the general population. Within these categories, target groups are further divided into levels, with the first level in each category receiving the vaccine first.

Ethical Concerns

Since allocating vaccines requires prioritizing groups as described above, ethical concerns are inherently involved. Ideally, pandemic preparedness plans will include guidance on what protocol to use when allocating vaccines so that first responders and health professionals would not have to make these decisions while responding to a pandemic. If possible, these plans should also outline procedures for prioritizing the use of medical facilities and equipment, quarantining infected individuals and possibly

[12] Texas Department of State Health Services, *Pandemic Influenza Preparedness Plan*, October 2005, p. 98.

separating families in the process.[13] In terms of vaccine allocation, most experts agree that first responders, medical personnel, and those controlling infrastructure should receive vaccines first. However, there is some contention relating to prioritizing the general population who do not fit into one of these three categories.

In 2006, the ACIP and NVAC released their recommendations for vaccine allocation in the event of a global flu pandemic. They recommended that the elderly, patients with at least two high-risk conditions (such as heart disease), and those with a history of severe pneumonia be vaccinated first. First responders, key leaders in government, healthy senior citizens, and those with one risk factor would receive the vaccine next, followed by utility, transportation, and telecommunications employees.[14] National Institutes of Health (NIH) researchers Ezekiel J. Emanuel and Alan Wertheimer developed another plan aimed at developing an alternative to the two primary principles in vaccine allocation: saving the most lives by prioritizing the elderly and a pure life-cycle approach, which aims at saving the most life years by prioritizing infants. Instead, they advocated what they termed an "investment refinement of life-cycle principle including public order" (IRPOP).[15]

Both the NVAC/ACIP and IRPOP approaches agree that vaccines should first be distributed to front-line medical staff and first responders first, as well as the military, which may be needed to impose order and uphold authority in a time of chaos. However,

[13] Julian Sheather, *Ethics in the Face of Uncertainty: Preparing for Pandemic Flu*, Clinical Ethics vol., 2006, p. 224-227.
[14] University of Pennsylvania Center for Bioethics, Vaccine Ethics.org, *The Rationing of Vaccines against Pandemic Influenza*, 2007, p. 2.
[15] Emanuel, Ezekiel J and Alan Wertheimer. *Who Should Get Influenza Vaccine When Not All Can?*, Science vol. 308, 2006, p. 854-855.

unlike the ACIP/NVAC approach, the IRPOP approach then gives priority to those in the 13 to 40 age group, including healthy individuals in this age range. A key principle guiding Emanuel and Wertheimer's model is saving the most "life-years" rather than the most lives. Accordingly, intensive monetary investments have been made for those in the 13 to 40 age group, but those investments are largely unfulfilled in terms of lifetime earnings, while minimal investments have been made in very young children. Likewise, although intensive investments have been made in the elderly population, those investments have largely been realized through earnings as well as contributions to society. Additionally, younger children do not receive the highest priority because they can be protected by social isolation, which involves taking measures such as closing schools and community centers.[16]

During the 80th Legislature, Texas lawmakers passed House Bill 3184, which required the Texas Health and Human Services Commission (HHSC) to conduct a study of the distribution of influenza vaccines in Texas order to determine the feasibility of giving priority in filling flu vaccine orders to physicians and other licensed health care providers.[17] The findings of this study, issued in May 2008, indicate that despite the benefits of giving priority to physicians, such as maintaining a patient's medical home and ensuring that medical records are complete and accurate, there are many disadvantages that affect public health. The study found that giving priority to physicians may decrease vaccination rates, increase the cost of vaccines, and reduce vaccine production capacity, which is critical to preparing for a pandemic. Vaccination rates may

[16] *Ibid*, p. 2.
[17] Texas House of Representatives, House Bill 3184, 80th Legislature, 2007.

decline among segments of the population who prefer to receive their flu shots outside of their physicians office, because such venues (retailers and workplaces, for example) would not receive their share of the vaccine until all physician orders have been filled. In addition, the cost of the vaccine may also increase if physicians are given priority due to increased shipping and distribution costs to distributors and manufacturers. These shipping and distribution costs can be expected to increase because numerous small shipments would be required instead of fewer large shipments sent to large retailers and employers. Finally, vaccine production capacity might be reduced if physicians are given priority because of the additional costs to manufacturers. In light of these possible consequences of giving physicians priority in receiving vaccines, the report offered other options for ensuring adequate vaccine supplies. These include requiring manufacturers and distributors to fill public health orders before those of retailers in order to ensure that participants in public vaccine programs receive their vaccine before retailers do; encouraging physicians to enter into group purchasing agreements to mitigate high vaccine costs and supply problems; and utilizing the Centers for Disease Control (CDC) Flu Finder system to track vaccine distribution.[18] During a pandemic, it is likely that other resources such as ventilators would also be scarce, which would require the development of guidelines to determine which groups receive these supplies first. While there has been extensive discussion among pandemic experts and ethicists to determine these guidelines, no consensus has been achieved to date.

According to a review of states' achievements in pandemic preparedness conducted by the Trust for America's Health, Texas has adequate plans to distribute emergency

[18] Morningside Research and Consulting, Inc., *Flu Vaccine Distribution in Texas*, May 14, 2008, p. 20-21.

vaccines, antidotes, and medical supplies from the SNS, and has also purchased a portion of its share of federally-subsidized or unsubsidized antivirals to use during a pandemic outbreak.[19] Additionally, a CDC evaluation of the state's plan to distribute SNS resources statewide in a public health emergency gave it a grade of 97 out of 100 and identified Texas' Antiviral Distribution Plan as a 'Best Practices' model for other states to follow.

Communication Plan

One of the major responsibilities of state officials before, during, and after a pandemic influenza is the dissemination of reliable and timely information to public health officials, medical care providers, the media, and the general public. As part of the National Strategy for Pandemic Influenza issued by the President in November 2005, states are required to develop comprehensive pandemic flu preparedness and response plans.[20] Current guidelines for communication between the state and these groups at each stage of a pandemic flu are detailed in the draft version of the Pandemic Influenza Preparedness Plan (PIPP), which was issued by the DSHS Pandemic Influenza Planning Group (PIPG) on October 24, 2005. The composition of the PIPG was determined by the Community Preparedness Section Leader, and is based on the organizational structure of DSHS with consultation provided through a contract with the Texas Forest Service ICS Support Team. In addition to having appropriate expertise within DSHS, the PIPG also includes representatives from the Texas Animal Health Commission, Texas Parks and Wildlife Commission, United States Department of Agriculture – Animal and Plant Health

[19] Trust for America's Health, *Ready or Not: Emergency Preparedness Indicators*, 2007, p. 18.
[20] U.S. Homeland Security Council , *National Strategy for Pandemic Influenza*, November 2005, p. 10-11.

Inspections Service, and the Texas Veterinary Medical Diagnostic Laboratory.[21] Details of this plan are discussed in more detail below. It is important to note, however, that although preparedness and planning for a pandemic influenza are essential, the plan must be flexible enough to allow for changes in medical technology, vaccine availability, the characteristics of the pandemic, and other factors that will be unknown prior to an outbreak.[22]

The PIPP offers detailed guidelines for the communication activities that should occur at every stage before, during, and after a pandemic flu. The PIPP separates pandemic influenza into five stages based on the World Health Organization's (WHO) Pandemic Phase Chart, introduced in 2005. The stages are:

1. Interpandemic Period: no new influenza virus subtypes have been detected in humans, although animals may have been infected at this stage;
2. Pandemic Alert Period: human infection has been detected and small and large (but localized) clusters of infected people form;
3. Pandemic Period: increased and sustained transmission between humans;
4. Subsided Period: period between pandemic waves, and;
5. Postpandemic Period: pandemic ends and the cycle returns to an Interpandemic Period.

[21] Texas Department of State Health Services, *Pandemic Influenza Preparedness Plan*, October 2005, p. 14.
[22] U.S. Department of Health and Human Services, *Draft Guidance on Allocating and Targeting Pandemic Influenza Vaccine*, October 17, 2007, p. 1.

The PIPP includes detailed communication plans and networks throughout each of these phases, the first two of which are discussed below.[23]

During the Interpandemic Period, the Health Alert Network (HAN) is activated. The HAN functions to increase communication capabilities between state and local health departments and ensures DSHS' ability to broadcast and receive health bulletins. The HAN covers approximately 87 percent of Texas' population through email, voice, and fax capabilities. It also contains key contact records for providers, hospitals, and community groups that need to receive alerts throughout a pandemic.[24]

Also during this period, the PIPG will enhance communications with health care providers and will also develop, revise, and update informational materials in an easy-to-read format available in multiple languages which educates the public on preventative practices such as hand washing, respiratory hygiene, and cough containment. PIPG will also develop a Pandemic Information CD-ROM for distribution to the general public, a webpage for the public to access through the DSHS Preparedness and Response website, and key messages and fact sheets relating to pandemic influenza issues.[25]

During the Pandemic Alert Phase, when some human to human infection has been confirmed, the PIPG will update and disseminate fact sheets and flyers as needed, maintain the website, and develop messages to the public regarding the pandemic, to be

[23] Texas Department of State Health Services, *Pandemic Influenza Preparedness Plan*, October 2005, p. 24.
[24] *Ibid*, p. 36.
[25] Texas Department of State Health Services, *Pandemic Influenza Preparedness Plan*, October 2005, p. 37.

distributed in partnership with the HAN. During this period the PIPG will also coordinate with bordering states, Texas-Mexico border jurisdictions, and their Mexican counterparts to give citizens consistent information. Communication with the media will be confined to designated DSHS spokespeople.[26]

Private Sector Involvement

Throughout the Interpandemic and Pandemic Alert Periods, DSHS and PIPG can identify and develop relationships with the private sector to reach special populations and disseminate information, as well as prepare businesses to mitigate the impacts of a pandemic. Since the private sector owns and operates over 85 percent of the country's critical infrastructure and collectively has daily contact with the majority of the population, it is important to involve them in all stages of pandemic preparedness, planning, and response.[27] Prior to a pandemic, state pandemic planning authorities may find it beneficial to work with businesses to create plans to educate employees and customers about preventative measures and what to do in the event of a pandemic. While it is in their best interests to take public health measures and create employee pandemic influenza education programs, businesses may also respond to tax or other incentives to enhance these activities and provide reporting services to state agencies on the performance of prevention and preparedness operations. Health care executives may also take leadership roles in collaborating with local health departments to educate their communities on how to protect themselves from the pandemic flu, how to care for sick

[26] *Ibid*, p. 47.
[27] Global Security.org, *National Strategy for Pandemic Influenza Implementation Plan One Year Summary*," 2007. Available: http://www.globalsecurity.org/security/library/report/2007/nspi-2007-03.htm

family members at home, and how to bring items into their homes virus-free. Engaging in these collaborative activities prior to the outbreak of a pandemic is likely to empower citizens and shift some responsibility to them.[28]

After a Pandemic Period begins, marked by increased and sustained transmission in the general population, strategies to communicate with the public continue as in the Pandemic Alert Period, with the PIPG and DSHS updating the public through regular news releases, updated fact sheets and flyers, and frequent website updates. Designated DSHS staff are responsible for communicating pandemic response updates and recommendations to health care professionals, according to the PIPP.[29] During the height of the pandemic, risk communication experts advise that public health officials should give the public accurate and timely information including details about the difficulties of dealing with the pandemic, rather than simply relaying facts and figures to the public. These experts emphasize the need to align public perception with realistic assessments of the pandemic and to use targeted communications to tie citizens' self-interests to the interests of the entire community.[30]

Other Issues

Depending on the severity and infection patterns that emerge during a pandemic, hospital evacuations might be necessary. Hospital evacuation is inherently dangerous for patients,

[28] Nancy A. Thompson and Christopher D. Van Gorder, *Healthcare Executives' Role in Preparing for the Pandemic Influenza 'Gap': A New Paradigm for Disaster Planning?,* Journal of Healthcare Management vol. 52, March/April 2007, p. 2.
[29] Texas Department of State Health Services, *Pandemic Influenza Preparedness Plan*, October 2005, p. 54.
[30] National Governors Association Center for Best Practices, *Preparing for a Pandemic Influenza: A Primer for Governors and Senior State Officials*, 2006, p. 14.

especially those who are medically fragile or have complicated medical needs. Hospital evacuations also disrupt the health care delivery system and present financial hardships and liability issues to the hospital and to health care workers. As mentioned previously, the establishment of alternative standards of care during pandemics could alleviate liability burdens faced by hospitals and medical providers during evacuations and pandemics.

It is also likely that, during a pandemic influenza, hospital supplies of ambulances would be severely diminished, making evacuation extremely difficult. Experts in hospital emergency preparation recommend making hospital evacuation the last resort in a pandemic, as has been done in the state of Florida. Additionally, they recommend developing a public education campaign that would inform citizens of who should and should not evacuate in different types of emergencies.

Conclusion

By all scientific and public health expert accounts, the question is not *whether* another pandemic will occur, but *when*. Preparation for such an event must anticipate the worst possible outcomes and be designed accordingly to ensure that supplies of vaccines, antivirals, and medical equipment are readily available and that a distribution plan is in place. Mass vaccinations and potential shortages of supplies involve ethical issues that must be addressed prior to a pandemic outbreak. While Texas is comparatively well-prepared for a pandemic influenza outbreak in terms of planning and communications, steps can be taken to better prepare the state for such an event.

Recommendations

1. **Continue to expand the capacity of nursing education programs.**

   Rationale: Texas has a shortage of health care professionals. Many hospitals routinely face a ten percent nurse shortage and by 2020 Texas is expected to face a shortage of 70,000 nurses.

2. **Reduce the rate of uninsured individuals without a medical home.**

   Rationale: One in four Texans, or 25 percent of the population, is uninsured. Uninsured Texans often do not have a Primary Care Physician (PCP) and use emergency rooms as their medical home.

3. **Increase the availability of funding to trauma hospitals.**

   Rationale: Trauma hospitals are on diversion status 30 percent of the time, on average, due to a lack of equipment and supplies.

4. **Develop alternate standards of care for emergencies and develop associated liability protections for providers, except in cases of gross negligence.**

   Rationale: In the event of a pandemic influenza, hospital employees who are not licensed to administer vaccines or distribute antivirals might have to perform these and other tasks. Additionally, due to over-crowding, medical personnel may have to administer care outside of traditional hospital settings.

5. **Create public service announcements to educate the public on how to care for immediate basic needs of others during a pandemic.**

   Rationale: Shortages of medical personnel during a pandemic may require that ordinary citizens provide immediate basic needs for themselves and others.

6. **Create a workgroup to determine the guidelines for allocating scarce medical resources during a pandemic.**

   Rationale: If shortages of medical supplies and equipment occur during a pandemic, there are currently no guidelines in place for allocating these resources to the general population or determining which target groups should receive those resources first. Any directive to create a workgroup to establish such guidelines should also be given a specific timeline for delivering recommendations to the legislature.

7. **Immediately allocate security forces to secure hospitals and clinics at the onset of a pandemic influenza outbreak.**

   Rationale: Limited supplies of vaccines and other supplies, as well as limited hospital capacity, could incite riots and encourage other criminal behavior.

8. **Make hospital evacuation the last resort in a disaster.**

   Rationale: Hospital evacuation is inherently dangerous for patients, especially those who are medically fragile. Evacuation disrupts the health care delivery system and in events like pandemic influenza that will deplete the supply of ambulances, hospital evacuation plans are likely to fail.

9. **Create a public education campaign to inform citizens about who should and should not evacuate in different types of emergencies.**

   Rationale: Educating the public will help ensure that unnecessary evacuees do not disrupt evacuation plans or impose exorbitant costs on the state or hospitals.

10. **Clarify state policies on financial and reporting requirements for waivers of the cost of caring for the uninsured during medical emergencies such as a pandemic influenza.**

    Rationale: Hospitals treat the uninsured during disasters such as pandemics, but are usually not informed in advance of what information should be gathered from patients and what services will or will not be covered.

Charge 10: Health Enterprise Zones

Study the potential for development of Health Enterprise Zones, which could offer tax incentives to medical providers who locate within the boundaries of designated medically underserved areas. Analyze similar legislation enacted in other states, specifically New Jersey, and estimate costs and benefits. Consider expanding incentives to medically related industries such as medical research facilities, laboratories and equipment manufacturers in order to spur economic development.

Underserved in Texas

Texas is underserved in terms of primary care physicians, mental health providers, and dentists.[1] Twenty-one percent of Texans, over 5 million people, reside in health professional shortage areas and medically underserved areas.[2] Currently, Texas has 114 "whole county" Health Professional Shortage Areas (HPSA) areas with a shortage of primary medical care, dental, or mental health providers.[3] An HPSA is determined based on the ratio of population to primary care physicians; a ratio of 3500:1 demonstrates that an area has a shortage of primary care physicians. The federal government may designate an HPSA in terms of geographic (a county or service area), demographic (low income population), or institutional (comprehensive health center, federally qualified health center, or other public facility) criteria.[4]

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[1] Senate Committees on Health and Human Services and International Relations and Trade, *Joint Interim Charge Report on Improving Healthcare Workforce*. 2008.
[2] Connie Berry, Texas Primary Care Office, Department of State Health Services, *Testimony before the Senate Committee on Health and Human Services*, May 28, 2008.
[3] Department of State Health Services, *HPSA Designations*. Available: http://www.dshs.state.tx.us/CHS/HPRC/PChpsaWC.shtm, Accessed: November 2008.
[4] 42 Code of Federal Regulations, Ch. 1, Part 5.

Texas has 178 whole county Medically Underserved Areas (MUA) and 108 partial county MUAs in 44 counties.[5] An MUA is a federal designation based on criteria that are indicative of the level of underservice:

1. the ratio of primary medical care physicians per 1,000 population;
2. the infant mortality rate;
3. the percentage of the population with incomes below the poverty level; and
4. the percentage of the population age 65 or over.

The Index of Medical Underservice (IMU) scale ranges from 0 to 100, in which 0 represents a completely underserved area and 100 represents best served or least underserved. Under the established criteria, each service area found to have an IMU of 62.0 or less qualifies for designation as an MUA. The federal government rarely updates MUA designations and the current designations are at least twenty years old.[6]

In February 2008, the federal government announced that it would change the MUA and HPSA definitions to encompass aspects of both definitions to better gauge the level of underservice in a given area.[7] The new methodology incorporates the clinical criteria of the MUA designation and the health professional ratios of the HPSA designation and will adjust for population variations.[8] The result is that Texas may lose a few dozen designations, but would retain most of them through surveying the disputed areas to

[5] Department of State Health Services, *MUA and MUP Designations*. Available: http://www.dshs.state.tx.us/CHS/HPRC/MUAlist.shtm, Accessed: November 2008.
[6] U.S. Department of Health and Human Services Health Resources and Services Administration, *Guidelines for Medically Underserved Area and Population Designation*. Available: http://bhpr.hrsa.gov/shortage/muaguide.htm, Accessed: November 2008.
[7] 42 Code of Federal Regulations, Part 5 and 51c. Available: http://bhpr.hrsa.gov/shortage/hpsafrn022908.htm, Accessed: November 2008.
[8] *Ibid*.

determine the lack the lack of access to health care.[9] Additionally, the new designation would allow the Primary Care Office to update the medically underserved designations more frequently, approximately every three years.

Previous Legislation

The legislature has undertaken steps to alleviate the disparities of medically underserved populations. Senate Bill 10, 80th Legislature, contained provisions to improve access to care for medically underserved communities, including improvements in access to Federally Qualified Health Centers (FQHCs), and to ensure proper payments for these centers.[10] House Bill 1579 directed the Texas Health and Human Services Commission (HHSC) to reimburse providers for care that they provide to Medicaid recipients in underserved communities outside of normal business hours.[11] House Bill 2542, 80th Legislature, narrowed the focus of the Office of Rural and Community Affairs (ORCA) to enable it to better focus on its mission, including improving rural health and community development.[12] ORCA administers and oversees the disbursements of Federal Rural Community block grants and has directed some of these funds to rural health programs and to assist underserved areas.

New Jersey Health Enterprise Zone Law

In 2004, the New Jersey Legislature enacted a law providing incentives for primary care medical and dental practices that locate or remain within a Health Enterprise Zone

[9] Supra note 2.
[10] Texas Senate, Senate Bill 10, 80th Legislature, 2007.
[11] Texas House of Representatives, House Bill 1579, 80th Legislature, 2007.
[12] Texas House of Representatives, House Bill 2542, 80th Legislature, 2007.

(HEZ), a state-designated medically underserved area. The New Jersey Commissioner of Health and Senior Services determines medically underserved designations, which the state defines as an urban or rural area or population group with a medical or dental manpower shortage. The Commissioner also ranks municipalities according to indicators that demonstrate a lack of access to comprehensive and timely primary health care services, including:

1. the percentage of the population below 200 percent of the poverty level;
2. the percentage of the population that is unemployed;
3. the per capita income, teenage pregnancy rate;
4. the rates of preventable diabetes; and
5. the age adjusted death rates.[13]

The purpose of an HEZ is to encourage primary care practices to remain located in or relocate to medically underserved areas, where many residents utilize emergency rooms as their primary care facilities. The New Jersey law has three main components:

1. a primary care medical or dental practice located in an HEZ will be allowed to deduct from its gross income the amount paid to the practice from the Medicaid program or the children's health insurance program (CHIP);
2. a primary care medical or dental program located in an HEZ will have access to a state administered low interest loan program for construction, renovation, or purchasing medical equipment for the practice; and
3. a municipality designated as medically underserved or an HEZ may pursue an ordinance that provides property tax exemptions for the portion of a building that

[13] New Jersey Medically Underserved Index, Available: http://www.state.nj.us/health/fhs/professional/documents/njmmu99.pdf, Accessed: November 2008.

houses a primary care medical or dental practice. The landlord of the property must submit an annual application to the tax assessor for this exemption, and the municipality rebates the amount of the exemption to the medical or dental practice tenant. The burden is on the practice to inform its landlord about the ordinance.[14]

The New Jersey law also allows practices located within five miles of an HEZ to access all of these benefits except for the optional property tax exemption. The requirements for eligibility are:

1. at least half of the gross receipts at the practice are from providing health care services to eligible recipients of Medicaid and CHIP; and
2. at least half of those eligible recipients are residents of an HEZ.[15]

The New Jersey Academy of Family Physicians (NJAFP) was the driving force behind the creation of HEZs.[16] After enactment of the law, the NJAFP continued to encourage municipalities to implement ordinances that grant owners a property tax exemption for the portion of their building used to house a healthcare provider. Currently, Newark is the only city government considering such a proposed resolution.[17] No municipality has enacted an ordinance to grant these property tax exemptions since the HEZ law took effect in June 2005.[18]

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[14] New Jersey Bill, A2638.
[15] *Ibid*.
[16] Champlin, Leslie, *Health Enterprise Zone Law Becomes Model for Others*, AAFP News Now. December 2005. Available: http://www.aafp.org/online/en/home/publications/news/news-now/archive/zonelaw.html, Accessed: November 2008.
[17] Kaplan, Ivan and Pagano, Stephan, *Health Service Tax Breaks are Jersey's Little Secret*, Real Estate Weekly. August 2, 2006. Available: http://72.14.205.104/search?q=cache:5Ghy3W_9JQoJ:www.encyclopedia.com/doc/1G1-150696359.html+%22health+enterprise+zone%22&hl=en&ct=clnk&cd=9&gl=us, Accessed: November 2008.
[18] *Ibid*.

Analysis of the Effectiveness of the Health Enterprise Zone Law

Because the health enterprise zone (HEZ) concept is new, there is little research or evidence with which to evaluate its effectiveness. The HEZ concept started in New Jersey because the state had no similar program. This dynamic may not be the case in other states. In January 2008, the Hawaii legislature introduced, but failed to pass, a health enterprise zone bill, House Bill 1996.[19] The bill attracted community support including Hawaiian healthcare and medical associations, but concerns were raised regarding the cost of the program, the effectiveness of the initiatives, and duplication of existing programs. The Hawaii Department of Business, Economic Development, and Tourism expressed a preference that healthcare providers be recognized as eligible businesses in already established enterprise zone programs, rather than enact a new, partly duplicative program.[20] The Department of Taxation estimated that the bill could result in a loss of approximately $1.3 million per year.[21] While supporters of HB 1996 lauded its goals, they stressed that its approach was only one avenue toward solving the problem of physician shortages in underserved areas.[22]

Problems with Income and Property Tax Exemptions

Some of the results from the New Jersey Health Enterprise Zone law have been disappointing. The New Jersey Budget Office discovered a problem with the portion of

[19] Hawaii Legislature House Bill 1996 (2008).
[20] Hawaii Department of Business, Economic Development, and Tourism, *Testimony before the Hawaii House of Representatives Committee on Health*. January 2008.
[21] Hawaii Department of Taxation, *Testimony before the Hawaii House of Representatives Committee on Health*, February 2008.
[22] Hawaii Medical Service Association, *Testimony before the Hawaii House of Representatives Committee on Health*, February 2008.

the law that granted income tax exemptions to practices within five miles of an HEZ. Upon consultation with medical and dental associations, the budget office discovered that no practice could be viable if half of its receipts were from Medicaid or CHIP.[23] This effectively rendered this component of the law moot.

The property tax component of the HEZ law has also been problematic. As referenced above, no community has been successful in implementing the property tax portion of the bill and only one has initiated an attempt to pass a measure to do so. The law did not require a municipality to grant a property tax exemption, but did require that if it did so, it must absorb the cost of lost property taxes.[24] For a municipality that may be underserved and economically depressed, the loss of property tax income may prove undesirable even if it could result in the attraction of doctors to the area. Currently, the New Jersey legislature is considering new legislation that would allow municipalities more latitude in granting property tax exemptions to medical offices.[25]

Additionally, the New Jersey HEZ law's property tax rebates are intended to serve as an inducement to healthcare workers to practice in HEZs. Property owners may rebate to a tenant an amount equal to the property tax exemption, either in a lump sum or through discounted rental payments. However, the procedure is complicated by the requirement that, each year, the landlord must pursue a tax exemption for which he or she receives no direct benefit. Advocates of the law argue that developers and commercial property

[23] New Jersey Legislative Fiscal Estimate. Available: http://www.njleg.state.nj.us/2004/Bills/A3000/2638_E1.PDF, Accessed: November 2008.
[24] *Ibid.*
[25] New Jersey Bill S-544. Available: http://www.njleg.state.nj.us/2008/Bills/S1000/544_I1.HTM, Accessed: November 2008.

owners benefit by having the ability to attract stable tenants to lease commercial space. The New Jersey Budget Office did determine that this component might result in a loss of property tax revenue.[26] However, other states that have attempted to create HEZs do not appear to have eliminated this component.

Applicability of a Health Enterprise Zone Law to Texas

Income Tax Exemptions

While Texas does not have a comparable health enterprise zone law, it does have mechanisms that function similarly to those in an HEZ. Texas does not have a state income tax, but the franchise tax contains a provision that allows primary care physicians and dentists to exclude 100 percent of their revenue from Medicare, Medicaid, CHIP, and TRICARE. The franchise tax also allows health care institutions and hospitals to exclude 50 percent of the revenue from Medicare, Medicaid, CHIP, and TRICARE.[27] Since the franchise tax exemption is already in effect and functions similarly to the income tax mechanism, the tax exemption in an HEZ law would have no additional fiscal impact on the state. Additionally, the franchise tax exemption is in effect statewide and benefits the entire state, not just select regions.

Infrastructure Grants and Loans

ORCA offers a number of grants for construction, renovation, or purchasing of medical equipment for practices in rural and underserved areas. These grants achieve a similar effect to the low interest loan program in the New Jersey HEZ law. Although only

[26] New Jersey Legislative Fiscal Estimate. Available: http://www.njleg.state.nj.us/2004/Bills/A3000/2638_E1.PDF, Accessed: November 2008.
[27] Texas Tax Code, Section 171.1011(n).

businesses in rural communities qualify for an ORCA grant, some rural communities are also underserved communities. The ORCA grants are limited to small rural communities, usually with populations under 5,000. Typically, the grants range from $50,000 to $150,000 and the communities may distribute them for small business infrastructure and development. ORCA also offers a microenterprise loan to communities that may be used for business development to benefit low to middle income individuals and offers an infrastructure grant program for MUAs. This grant program provides up to $50,000 for development of a physician practice and requires a community to provide matching funds in order to receive a state grant. The state makes $250,000 available for this program annually. However, a low interest loan component of an HEZ bill may create little or no fiscal cost to the state because physicians would be required to repay the loan funds. The ORCA programs may achieve similar results, but create a larger fiscal impact to the state.

Property Tax Incentives

Texas has no statewide property tax, but state law allows local taxing units to enact special property tax provisions for economic development in enterprise zones.[28] While state property tax law refers to enterprise zones, this is an economic development designation. It is likely that some economic development enterprise zones overlap with MUAs or HPSAs. School districts cannot enter into agreements for tax abatements, but incorporated cities, counties, and special districts can do so.[29] Property owners can receive property tax refunds if they establish a new business in a reinvestment zone or

[28] Texas Comptroller, *Window on State Accounts: Reinvestment Zone for Tax Abatement Registry*. 2004. Available: http://www.window.state.tx.us/taxinfo/proptax/registry04/abate.html, Accessed: November 2008.
[29] *Ibid.*

expand or modernize an existing business located in the zone and increase their business' payroll by at least $3 million. An owner must also increase the abated property's appraised value by at least $4 million.[30] As stated above, many physicians' practices do not own the property in which they reside. Few practices have payrolls of $3 million or property worth $4 million.

Under the Texas Development Corporation Act, cities may establish 4A and 4B corporations to administer sales and use tax funds.[31] 4A and 4B corporations may use sales taxes for manufacturing and industrial facilities, research and development facilities, recycling facilities, distribution centers, small warehouse facilities and distribution centers, military facilities, primary job training facilities, corporate headquarter facilities, job training classes, career centers, telephone call centers, business infrastructure, airport facilities, and operation of commuter rail, light rail, or commuter buses.[32] The Development Corporation Act also allows communities to fund primary job training facilities for use by institutions of higher education, including public technical institutes, public junior colleges, public senior colleges or universities, and medical or dental schools.[33]

Because some underserved communities cannot afford to lose additional property revenue, they could have an interest in leasing or converting public property for use by a physician's practice and use the reduced rent or property tax exemptions as an

[30] Texas Comptroller, *Tax-Related State and Local Economic Development Programs*. 2007. Available: http://www.window.state.tx.us/specialrpt/stateloc07/stateloc07.pdf, Accessed: November 2008.
[31] *Ibid.*
[32] *Ibid.*
[33] *Ibid.*

inducement for physician practices. However, in 2000 the State Attorney General issued a ruling that a building owned by Karnes County Hospital District and leased to physicians for their private medical practice was not exempt from property taxes. Private commercial use of publicly owned property removes the tax-exempt status of a public property.[34]

Economic Incentives to Medically Related Industries and Research Facilities

In 2003, the 78th Legislature passed House Bill 3629, the Temple Health and Bioscience Economic Development District bill. Under the provisions of the bill, the district, located in Temple, Texas, may enter into contracts, establish fees, and implement economic development programs and projects. The district may impose property assessments, incur liabilities, issue bonds or other obligations, and impose an ad valorem tax subject to voter approval. To date, the district has not enacted such a tax; instead it typically finances projects through revenue bonds. The district also owns properties and leases them to industries.

The district serves mainly to champion the projects of industries located within its boundaries. It has not focused on attracting industries, but can assist, to a limited degree, in attracting business, generally using grants. The Temple Economic Development Corporation provides most of the focus on attracting new industry to the city using larger grant programs and tax incentives. It is currently engaged in building a bioscience business park, made possible by the city's already established resources in the bioscience

[34] Texas Attorney General, *Opinion No. JC-311*. Available: http://www.oag.state.tx.us/opinions/opinions/49cornyn/op/2000/pdf/JC0311.pdf, Accessed: November 2008.

field, including Scott and White Hospital (an academic medical center) and the U.S. Department of Veterans Affairs. Industry partners have stressed that having a trained workforce is important to attracting medical and bioscience jobs. In addition, related industries tend to cluster in areas where they have the resources necessary to develop intellectual property. For such reasons, an economic development district like Temple's may not be beneficial for underserved areas lacking a nearby university, college, or established medical or bioscience resources.

Health or Medical Enterprise Zone Provisions in Other States

A sales tax reduction or exemption on medical equipment for physician practices in MUAs can reduce the barrier to establishing physician practices in MUAs. Florida offers a sales tax exemption for purchases on medical equipment and supplies by health care facilities located in an enterprise zone.[35] The exemption applies only after the taxpayer has paid $100,000 in sales tax in a calendar year.[36]

In 2007, the California legislature introduced but did not pass legislation to establish up to ten Medical Enterprise Zones in medically-underserved areas located in Enterprise Zones.[37] Communities must apply to receive the medical enterprise zone designation in a competitive application process. Qualifying taxpayers, located in a medical enterprise zone, could receive a five-year tax credit for hiring health care professionals whose

[35] Florida State Senate Bill, S. 212.08 (2) (a)-(k) (2007) F.S. Available: http://www.flsenate.gov/Statutes/index.cfm?mode=View%20Statutes&SubMenu=1&App_mode=Display_Statute&Search_String=&URL=CH0212/Sec08.HTM, Accessed: November 2008.
[36] *Ibid.*
[37] California Bill AB-1134. 2007. Available: http://www.ftb.ca.gov/law/legis/07_08bills/ab1134_022307.pdf, Accessed: November 2008.

services are performed in the zone, sales tax credits on purchases of medical equipment, and an unspecified credit for the support of a qualified primary care residency training program.[38]

Conclusion

Texas has underserved diverse medically underserved areas and has taken previously taken steps to address shortages. Many states have taken varying approaches to creating programs to deal with similar shortages. The New Jersey Health Enterprise Zone law is new and has shown mixed results. While there are some programs in effect in Texas that parallel the incentives of the HEZ program, current law does not allow the property tax incentives for physicians' practices. It does make it easier for communities to provide incentives for larger scale operations, such as hospitals, but not for smaller physicians' practices or dentists' offices. Offering infrastructure loans and grants, property, or sales tax exemptions may be ways for the state to reduce barriers to providing access to care for the medically underserved. Although they would appreciate programs that make establishing a practice easier, physicians continue to state that they are most receptive to programs that help them eliminate their sizeable medical school loan debt. In sum, enacting a HEZ bill in Texas could be largely duplicative of existing programs.

Recommendations

1. **Enact the two portions of the New Jersey HEZ bill that could be applied to Texas: a low interest loan program for construction, renovation, or**

[38] *Ibid*.

purchasing medical equipment for the practice and allowance for property tax exemptions for primary care medical or dental practices in enterprise zones.

Rationale: A low interest loan program and property tax exemptions could decrease the barrier to entry for physician practices that seek to operate in underserved areas.

2. **Expand ORCA funding and programs to make more grants and loans available to physicians' practices.**

   Rationale: Enhancing current programs to meet already quantified needs could reduce duplication of efforts.

3. **Increase funding for medical school loan repayment in underserved areas.**

   Rationale: This approach could provide a cost-effective way of increasing the physician workforce in Texas because physicians tend to practice within 100 miles of where they complete their residencies.

4. **Amend the Development Corporation Act to allow communities to offer sales tax deductions or exemptions for purchase of medical equipment for practices in enterprise zones that also have MUA designations.**

   Rationale: Sales tax deductions or exemptions on costly medical equipment could further reduce the barrier to establishing new medical practices.

Charge #11: Adult Stem Cells

Monitor the collection and availability of cord blood stem cells for treatments and research in Texas. Review the current state of basic and clinical research using these and other types of adult stem cells. Assess the potential for clinical and economic benefits from current and increased adult stem cell research.

Background

Stem cells have been hailed in the bioscience and medical communities as the key to finding cures for diseases such as Parkinson's and Alzheimer's. Adult stem cells, which come from bone marrow, umbilical cord blood, or mobilized peripheral blood, are currently used in over 30 institutions in Texas either in a research capacity or to treat diseases.[1] Transplants of these stem cells have been used to treat about 70 different diseases in almost 20,000 patients in recent years.[2]

Stem cells reside in tissues and are not activated until there is a disease or tissue injury. Adult tissues that contain stem cells include the brain, bone marrow, peripheral blood, blood vessels, skeletal muscle, skin, and liver. Adult stem cells are undifferentiated cells (cells that have not yet generated structures or manufactured proteins characteristic of a specialized type of cell) found among differentiated (specialized) cells in an organ or tissue. Their primary role is to maintain and repair the organs and tissues in which they are found by renewing themselves and differentiating to yield the major specialized cell

[1] Peripheral blood cells are immature blood cells in the circulating blood that are similar to those in the bone marrow.
[2] Institute of Medicine of the National Academies, *Cord Blood: Establishing a National Hematopoietic Stem Cell Bank Program*, April 14, 2005, p. 14.

types. When a tissue is injured, signals are sent to the blood stream to recruit stem cells to repair the damaged tissues.[3] However, the process of stem cell recruitment often takes too long in the event of a life-threatening injury or organ failure.[4] A current goal of adult stem cell research is to develop strategies and tools to boost this repair function.[5]

Umbilical Cord Blood Stem Cells

For over 30 years, scientists have been performing bone marrow transplants using adult stem cells to treat leukemia, sickle-cell anemia, bone marrow damage, and other diseases. Extracting bone marrow is a painful and invasive procedure, and the donor and recipient must be genetically similar.[6] More than 70 percent of children and adults requiring a bone marrow transplant do not have an immune-matched sibling who could be a donor, resulting in 10,000 to 15,000 Americans each year who need transplants but are unable to find a match.[7] In recent years, however, scientists have used stem cells from umbilical cord blood shortly after a baby is delivered. Umbilical cord blood transplants are preferable to bone marrow transplants because they do produce a much lower incidence of graft-versus-host disease. This is a condition whereby the introduced stem cells attack the patient's existing tissue cells. Therefore, cord blood transplants don't have to be as carefully matched to recipients as bone marrow transplants do. Using stem cells from cord blood is also much less invasive than bone marrow transplants, since the stem cells are found in the umbilical cord and placenta and extraction does not affect the mother or

[3] National Institute of Health , *Regenerative Medicine*, 2006, p. 2-3.
[4] Dr. James T. Willerson, Texas Heart Institute, *Testimony before the Senate Committee on Health and Human Services*, Austin, Texas, October 13, 2008.
[5] *Dr. Larry Denner, Stark Diabetes Center*, *Testimony before the Senate Committee on Health and Human Services*, Austin, Texas, October 13, 2008.
[6] National Institute of Health, *Stem Cell Basics,* 2006.
[7] Texas Cord Blood Bank, Online at: http://www.bloodntissue.org/texascordbloodbank.asp

infant. Another advantage of using cord blood stem cells versus a bone marrow transplant is that cord blood stem cells are ready for use as soon as it is needed, while it takes weeks to months to contact and test donors listed in a bone marrow registry. Cord blood stem cells can be used to treat over 70 diseases and have already been used to treat certain cancers, inherited diseases, and diseases of the immune system.[8] There are, however, disadvantages to using cord blood stem cells, primarily that cord blood transplants take a week longer than bone marrow transplants to engraft, or repopulate the patient's blood supply so that the cell counts reach minimum acceptable levels. This longer engraftment time poses the risk of leaving the patient vulnerable to fatal infections for a longer period of time. Additionally, cord blood collections typically only contain enough stem cells to transplant to a large child or small adult. However, this problem can often be overcome by growing more cells in a laboratory prior to transplanting them, or by transplanting more that one cord blood unit at a time.

Texas Cord Blood Bank

The Texas Cord Blood Bank is a division of the South Texas Blood and Tissue Center in San Antonio. In 2001, the 77th Legislature directed the Health and Human Services Commission (HHSC) to create a program to award grant money for the establishment of a statewide umbilical cord blood bank for recipients of cord blood who are unrelated to the donors.[9] Also in 2001, HHSC was appropriated $2 million in contingency funding to establish the Cord Blood Bank.[10] An additional $3 million was appropriated in 2003 and in 2007, $4 million was appropriated for the Cord Blood Bank and $1 million was

[8] Institute of Medicine of the National Academies, supra note 1.
[9] Texas House of Representatives, House Bill 3572, 77th Legislature, 2001.
[10] Texas House of Representatives, House Bill 1, 77th Legislature, 2001.

appropriated for umbilical cord blood research.[11] [12] Also in 2007, the Appropriations Act contained rider 55 (Article II), which instructs HHSC to pursue federal approval for Medicaid reimbursement for consultations provided to Medicaid-eligible mothers regarding the collection of umbilical cord blood.[13]

The Cord Blood Bank first began collecting umbilical cord blood at Methodist Hospital in San Antonio in June 2005. Since then, new collection sites were opened at Valley Baptist Medical Center-Harlingen, Valley Baptist Medical Center-Brownsville, Medical City Hospital in Dallas, McKenna Hospital in New Braunfels, Texas Children's Hospital on Houston, Doctor's Hospital in McAllen, and North Central and Southeast Baptist Hospitals in San Antonio. Collections made at these hospitals are processed and shipped to the Texas Cord Blood Bank in San Antonio where the blood is tested. If the blood meets all quality standards, it is then stored and made available to transplant centers. If a unit of blood can be matched with a patient in need, the Texas Cord Blood Bank will make that unit available to the patient.[14] There is no charge for donating umbilical cord blood.

The 80th Legislature passed House Bill 709, which required the Executive Commissioner of HHSC to prepare a brochure regarding stem cells contained in umbilical cord blood.[15] The Department of State Health Services (DSHS) was required to make the brochure

[11] Texas House of Representatives, House Bill 1, 78th Legislature, 2003.
[12] Texas House of Representatives, House Bill 1, 80th Legislature, 2007.
[13] *Ibid.*
[14] Mary Beth Fisk, Texas Cord Blood Bank, *Testimony before the Senate Committee on Health and Human Services*, Austin, Texas, October 13, 2008.

[15] Texas House of Representatives, House Bill 709, 80th Legislature, 2007.

available on its website and to distribute it upon request to physicians or other health care providers to pregnant women during gestation or at the time of the delivery of an infant. Health care providers are required to provide pregnant women with the brochure and to permit the mother to arrange for umbilical cord blood storage or donation upon request of the mother unless donation threatens the health of the mother or the infant.

Availability of Cord Blood Donation Facilities

In addition to the hospitals served by the Texas Cord Blood Bank, the M.D. Anderson Cord Blood Bank has established donation facilities at Women's Hospital of Texas, Ben Taub General Hospital, and Memorial Herman Southwest Hospital, all located in Houston. Despite the number of hospitals equipped to accept and process cord blood donations throughout Texas, there are still large portions of the state where cord blood donation is not an option because of the lack of availability of this service. While storing cord blood to a private bank, which may only be accessed by the baby's family, costs the patient close to $2,000, donating cord blood to a public bank is free for the patient. However, due to the costs of collection, processing, shipping, and increasingly stringent regulations, each donation costs the cord blood bank about $1,500.[16] In order to save donations on a registry for potential transplants, the bank must have income to support the laboratory.[17] Since both the Texas Cord Blood Bank and the M.D. Anderson Cord Blood Bank are non-profit organizations aimed at creating banks available to the public,

[16] Mary Beth Fisk, Texas Cord Blood Bank, *Testimony before the Senate Committee on Health and Human Services,* Austin, Texas, October 13, 2008.
[17] Parent's Guide to Cord Blood Foundation, accessed at: http://parentsguidecordblood.org/content/usa/banklists/publicbanks_new.shtml?navid=14.

they typically do not store cord blood for private use, which would generate income. [18] Therefore, their funding is limited to grants, donations, and federal and state funding. Hospitals equipped to accept cord blood donations must employ at least one trained staff person to collect, process, and ship the cord blood. When a hospital enters into a contract with one of the public cord blood banks, they generally agree to hire such a staff person provided that the cord blood bank pay for or reimburse the salary of the staff member, in addition to the costs of collection, storage, and shipping.[19]

Potential Clinical and Economic Benefits

Supporters of adult stem cell therapies believe that it is a much more effective and less controversial method of harnessing the scientific promise of stem cells than using embryonic stem cells. Cord blood stem cell transplants have already been used to treat such diseases as leukemia, sickle-cell anemia, and cerebral palsy. Currently, research and clinical trials are being conducted to explore other applications of cord blood stem cells. For example, in 2007 a discovery was made by medical researchers at the University of Texas Medical Branch at Galveston (UTMB) indicating that adult stem cells derived from cord blood can be engineered to produce insulin, an extremely promising development in the quest to find a cure for diabetes.[20] Another 2007 study showed that many of the patients in a clinical trial were able to discontinue use of insulin after

[18] In cases of demonstrated medical urgency, the Texas Cord Blood Bank will store cord blood for private use at no charge.
[19] Mary Beth Fisk, Texas Cord Blood Bank, November 19, 2008.
[20] The University of Texas Medical Branch, *Researchers Report Success Engineering Adult Stem Cells From Human Umbilical Cord Blood to Make Insulin*, May 25, 2007.

receiving injections of their own adult stem cells.[21] Other major areas of clinical research on cord blood and other adult stem cells that are in the early stages include improving the treatment of hematological disorders, intravenous therapy in heart attack patients, and using adult stem cells to treat cancer by shrinking tumors.[22] While results from these early trials are extremely promising, much more research must be undertaken before cord blood stem cell treatment of these diseases is fully understood and transferable to treatment protocols.

Beyond the obvious potential for developing and improving life-saving treatments using cord blood stem cells, clinical advancements would also yield economic benefits for the state. First, improving treatment options for the diseases mentioned above, particularly cancer and diabetes, would dramatically decrease the burden of health care costs for the state. Additional economic benefits would result if Texas became a leader in the field of adult stem cell research and clinical applications. One of the most renowned and well-respected research and treatment centers for the use of cord blood cells is The University of Texas Health Sciences Center in Houston (UTHSC). UTHSC has the infrastructure, high-tech facilities, and patient base necessary to facilitate not only research into further uses for cord blood stem cells but also clinical applications to treat patients. This facility could draw highly trained and specialized scientists to the state, create jobs, increase sales, and local tax revenues, maintain and expand the presence of the pharmaceutical

[21] Adam Voiland, *A Preliminary Study Shows Adult Stem Cells Fight Diabetes*, U.S. News and World Report, April 11, 2007.
[22] Dr. Frank Morini, M.D. Anderson Cancer Treatment Center*, Testimony before the House Appropriations Subcommittee on Adult Stem Cells*, Austin, Texas, May 21, 2008.

and biosciences industries in Texas, and increase intellectual property payments to the state.[23]

Challenges of Advancing Research of Adult Stem Cells

The most significant obstacles to the potential benefits of adult stem cells are coordination and funding. In terms of coordination, while there are over 30 sites in the state where adult stem cell research and therapies are being conducted, the sites are not well coordinated, so best practices and results of research are frequently not shared. One possible model for the coordination of adult stem cell research and treatment facilities is the Texas Alzheimer's Research Consortium. Supported through state funds and created by the 76th Legislature (House Bill 1504), the Consortium promotes collaborative research between several research and treatment centers across the state and has created the nation's first centralized Alzheimer's database which combines the clinical, neuropsychological, and laboratory information on these research subjects collected at the various institutions.[24] Although no state funding was appropriated for the Consortium during the 76th Legislative Session, state funding from 2005 through 2009 totaled nearly $6 million.[25] Following this model could be beneficial in coordinating the work of the many sites where cord blood stem cells are researched and used in treatments, as well as advancing efforts to commercialize adult stem cell products and technologies.

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[23] Dr. Joseph J. Seneca, *Updated Economic Benefits of the New Jersey Stem Cell Capital Projects and Research Bond Acts*, Rutgers University Edward J. Bloustein School of Planning an Public Policy, October 2007.
[24] Texas House of Representatives, House Bill 1504, 76th Legislature, 1999.
[25] The Texas Alzheimer's Research Consortium, *Testimony before the Senate Committee on Health and Human Services*, Austin, Texas, October 13, 2008.

The funding question is a recurring theme because there are few sources of funding available specifically for adult stem cell research. To date, seven states, including Texas, have received federal funding to open public umbilical cord blood banks.[26] The Health Resources and Services Administration (HRSA), part of the U. S. Department of Health and Human Services (HHS), oversees the national organ and tissue transplantation system and is charged with awarding funds to public cord blood banks to begin collections for the National Cord Blood Inventory (NCBI). The NCBI collects and maintains high-quality cord blood units and makes them available for transplantation through the C.W. Bill Young Cell Transplantation Program. Among the nearly $20 million in federal funding allocated thus far, the M.D. Anderson Cord Blood Bank in Houston received $3,001,248 in 2006 and the Texas Cord Blood Bank in San Antonio received $1,660,220 in 2007.[27] Additional federal funding is available through the National Institutes of Health (NIH). However, in the past several years as the economy has taken a downturn and the federal government has attempted to cut spending, the bio-science research field has experienced across-the-board cuts in funding.[28] Additionally, grants for cord blood stem cell research are available through universities, the Texas Higher Education Coordinating Board, and the Emerging Technology Fund. The Texas Higher Education Coordinating Board (THECB) Advanced Research Program-Advanced Technology Program (ARP-ATP), created by the 70th Legislature in 1987, is a statewide grant program that supports individual investigator research at Texas' higher education

[26] Parent's Guide to Cord Blood Foundation, accessed at: http://parentsguidecordblood.org/content/usa/banklists/publicbanks_new.shtml?navid=14.
[27] U.S. Department of Health and Human Services Health Resources and Service Administration, *HRSA Awards $2.2 Million to Increase Collection of Cord Blood Units for National Inventory*, September 24, 2007.
[28] Department of Stem Cell Transplantation and Cellular Therapy at the University of Texas M.D. Anderson Cancer Center, *Testimony before the House Appropriations Subcommittee on Adult Stem Cells*, Austin, Texas, May 21, 2008.

institutions. The goals of the program are to develop a pool of highly trained specialists in the state, develop new technologies, and support research that will strengthen Texas industries. Since 1987, the program has awarded over 3,000 grants using $483 million in state funding. These grants have attracted $1.7 billion in additional external funding, with a $6.2 billion economic impact on the state.[29] This program is one source of funding for cord blood stem cell research, although grants are typically small. The Texas Emerging Technology Fund (TETF) is a $200 million program created by the 79th Legislature through House Bill 1765 to award grants to Texas companies and universities in order to increase research collaboration between public and private entities, match research grants provided by both federal and private sponsors, and attract more top-notch research teams from other universities around the country.[30] The TETF was re-authorized by the 80th Legislature, with over $185 million appropriated during the 2008-09 biennium. To date, the TETF has awarded more than $110 million to Texas companies and research institutions, including the following:

1. $5 million awarded in May 2008 to recruit scientists and surgeons in trauma care and new medical technologies at the University of Texas Health Science Center at Houston (UTHSC-H);[31]
2. $6 million awarded in July 2007 to recruit biotechnology researchers to the Texas Institute for Preclinical Studies (TIPS), an investment which leveraged $40 million in additional external funding for the Institute,[32] and;

[29] Texas Higher Education Coordinating Board, *Advanced Research Program (ARP)-Advanced Technology Program (ATP)-Technology Development and Transfer Program (TDT) Factsheet*, available at: http://www.thecb.state.tx.us/reports/pdf/0760.pdf.
[30] Texas House of Representatives, House Bill 1765, 79th Legislature, 2005.
[31] Office of the Governor, *State Leaders Announce Emerging Technology Fund Investment in Trauma Care Research*, May 9, 2008.

3. $250,000 awarded in March 2008 to Halsa Pharmaceuticals, Inc. for the development and pilot manufacturing of a therapeutic drug treatment for obesity.[33]

The Emerging Technology Fund is one potential source of funding for further adult stem cell research. Private funding through grants and donations also offer a promising source of funding for adult stem cell research.

Conclusion

The primary purpose of adult stem cells is to maintain and repair the organs and tissues in which they are found. This repair function has allowed the use of adult stem cells to treat 70 different diseases in almost 20,000 patients in recent years. In addition to traditional bone marrow transplants, umbilical cord blood transplants have emerged in recent years as a less painful alternative with diminished risk of patients developing complications from transplantation, such as graft versus host disease. Additionally, cord blood can be donated and stored for future use to stave off disease and repair organs and tissues. Investing in and coordinating research and treatment efforts in adult stem cell therapies present an opportunity for Texas to position itself as a leader in adult stem cell technology, and to drastically advance clinical medicine in the state.

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[32] Office of the Governor, *Texas Breaks Ground on Innovative Pre-Clinical Research Institute*, March 28, 2008.
[33] Office of the Governor, *Governor Perry Announces Emerging Tech Fund Investment in Halsa Pharmaceuticals*, March 24, 2008.

Recommendations

1. **Establish an Adult Stem Cell Research Consortium to encourage collaboration between the institutions of higher education in the state conducting research and developing medical treatments using adult stem cells.**

   Rationale: Adult stem cells are currently used in over 30 institutions throughout Texas either in a research capacity or to treat diseases. Research findings and opportunities for commercialization of products or technologies involving adult stem cells are not shared between institutions. A research consortium would allow institutions of higher education making advances in research and treatments to exchange information and collaborate on projects that would lead to the commercialization of adult stem cell products, potentially providing significant medical and economic benefits to the state.

2. **Continue to improve and promote the Texas Cord Blood Bank brochure created by House Bill 709, passed by the 80th Legislature.**

   Rationale: The brochure distributed to pregnant mothers informing them about the Texas Cord Blood Bank has been effective in educating the public about the usefulness of collecting and storing cord blood. However, clarifications need to be made to the brochure to outline the limitations of umbilical cord blood, the differences between donated and private

cord blood banking, and the importance of federal oversight of cord blood banks.

3. **Provide funding for scientist salary increases to attract them to Texas adult stem cell research and treatment centers.**

   Rationale: Leaders in adult stem cell research at institutions of higher education throughout Texas find that funding is the primary barrier to recruitment. They report being unable to attract and retain the best scientists in the field because they are unable to offer them competitive compensation packages.

4. **Utilize the Texas Emerging Technology Fund to finance adult stem cell research and commercialization.**

   Rationale: The Texas Emerging Technology Fund (TETF), a $200 million program created by the 79th Legislature through House Bill 1765, awards grants to Texas companies and universities in order to increase research collaboration between public and private entities, match research grants provided by both federal and private sponsors, and attract more top-notch research teams from other universities around the country. Utilizing this source of funding would advance adult stem cell research endeavors in the state.

5. **Support the Texas Cord Blood Bank's efforts to enable hospitals to accept umbilical cord blood donations.**

   Rationale: Donating cord blood helps save lives and treat future diseases and should be an available option to all new parents. While several hospitals throughout the state are capable of accepting cord blood donations, there are large regions of the state with no nearby access to such facilities. The public cord blood banks in Texas generally do not accept private cord blood donations, leaving them dependent on state and federal funds, as well as grants and monetary donations. Continuing to support the Texas Cord Blood Bank would allow them to expand donation facilities in hospitals in underserved areas of the state.

Joint Charge 2: Health Care Workforce

Study the state's current and long-range need for physicians, dentists, nurses, and other allied health and long-term care professionals. Make recommendations on how the state can help recruit high-need professions, especially for primary care providers and long-term care professionals in the underserved regions of Texas.

(Lt. Governor David Dewhurst's Interim Charge to the Senate Committee on International Relations and Trade directed the committee to focus on the Border Region of Texas. The Senate Committee on International Relations and Trade has issued a Select Border Focus Report.)

Background

Shortages in Texas

Population growth in Texas continues to outpace that of the nation; Texas is growing twice as fast as the US population.[1] As the state's population continues to increase, the issue of access to health care professionals intensifies. The expanding demand for health care professionals will continue to overburden the health care providers in the state. Currently, 45 percent of Texas' 254 counties are designated whole-county Health Professions Shortage Areas (HPSAs) by the federal government.[2] Additionally, 195 counties are or contain Primary Care HPSAs, 142 Dental Care HPSAs, and 205 Mental

[1] Dr. Ben Raimer, Statewide Health Coordinating Council, *Testimony before the Senate Committee on Health and Human Services and Senate Committee on International Relations and Trade*, (Austin, TX, May 28, 2008).
[2] Department of State Health Services Texas Primary Care Office, *Primary Care HPSA Designations*, Available: http://www.dshs.state.tx.us/CHS/hprc/PChpsaWC.shtm, Accessed: November 2008.

Health HPSAs.[3] Over five million people live in HPSAs. One hundred and seventy eight counties are either Medically Underserved Areas (MUAs) or contain Medically Underserved Populations.[4]

A number of factors influence health care workforce supply, including an aging workforce, distribution of health care professionals among specialties, salary and benefit issues for providers, working conditions of providers, the educational capacity of the medical education system, and ability of providers to retain clinicians.[5] Other factors impact demand for health care providers, including the aging population, scope of practice changes, medical advances, insurance coverage, insurance reimbursements, population growth, and the rate of chronic illness.[6] If nothing is changed, these factors will work against each other to further increase the distance between demand and supply.

Underserved Areas

Of Texas' 254 counties, 177 are rural.[7] Of the 32 border counties, 28 are rural.[8] While all portions of the state are affected by the health care workforce shortages, rural areas and border areas with HPSA or MUA designations are especially hard hit. Rural and border counties tend to have higher poverty rates, which can increase the need for physicians. Additionally, a higher poverty rate means an increase in the Medicaid population, which makes the health care providers who care for this population more

[3] Department of State Health Services Texas Primary Care Office, *Health Professional Shortage Areas (HPSAs) in Texas*, Available: http://www.dshs.state.tx.us/CHS/hprc/hpsa.shtm, Accessed: November 2008.
[4] Department of State Health Services Texas Primary Care Office, *MUA and MUP Designations*, Available: http://www.dshs.state.tx.us/CHS/HPRC/MUAlist.shtm, Accessed: November 2008.
[5] Supra note 1.
[6] *Ibid*.
[7] *Ibid*.
[8] *Ibid*.

dependent on adequate Medicaid reimbursements. Medical providers in these counties tend to be slightly older and closer to retirement, exacerbating the supply pressures in rural counties. In addition, rural counties tend to have a higher proportion of seniors than the state as a whole, increasing the level of need for specialists in geriatric medicine. Border counties have a higher proportion of the under-18 population and so require more specialists in pediatric medicine. Sparse public transportation and large distances between patients and health care providers in rural areas make the continuous provision of health care very difficult. Border counties also need a larger supply of culturally competent health care providers than other parts of the state.[9]

The projected growth for the 32 border counties and the rest of the state from 2000 to 2040 indicates that Texas is projected to grow to 25 million by 2010, and to over 51.7 million by 2040.[10] It is also estimated that the number of adults over age 65 will double between the years 2000 and 2025. The health needs of Texans will greatly increase, and proactive planning today will mitigate some of the challenges we face.

Current Workforce Initiatives and Recent Legislation

To better understand the state's workforce needs, in 2007, the 80th Legislature enacted Senate Bill 29, which directed all the state boards, agencies, and associations that license and register health professionals to provide information about licensing and shortages of health professionals to the Statewide Health Coordinating Council (SHCC). The purpose

[9] Comptroller of Public Accounts, *Texas in Focus: A Statewide View of Opportunities: Health Care*, Available: http://www.window.state.tx.us/specialrpt/tif/healthcare.html, Accessed: November 2008.
[10] Dr. Karl Eschbach, State Demographer, *Testimony before the Senate Committees on Health and Human Services and International Relations and Trade*, (Austin, TX, May 28, 2008) Available: http://txsdc.utsa.edu/tpepp/2006projections/summary/, Accessed: November 2008.

of this information is to allow the council to develop a clearer understanding of the state's health care workforce needs. SB 29 was the result of recommendations by the Texas Health Care Policy Council, created through House Bill 916 by the 79th Legislature. The purpose of the Council is to monitor the state's health workforce conditions and needs of Texas.[11] The Council's recommendations focused on the need for more and better workforce data, better coordination, and collaboration among educational institutions and more efficient use of workforce resources and led to the passage of SB 29.[12]

Physician Initiatives

House Bill 1973, by 80th Legislature, directed the Texas Medical Board (TMB) to annually review its procedures for granting licenses. The bill also required the Board to ensure that the average time to process a license application does not exceed 51 days and to give priority to applicants who plan to practice in underserved areas.[13] The Board was granted six additional FTE's and $1.2 million to accomplish the licensure goal.

Senate Bill 10, during the 80th legislative session, authorized the Texas Health Care Policy Council to study increasing the number of medical residency programs and the number of physicians practicing specialties.

[11] Texas House of Representatives, House Bill 916, 79th Legislature, 2005.
[12] Health Care Policy Council, *Commitment to Health Workforce Needs: A Strategy for Addressing Texas' Health Workforce Needs: Strategic Plan 2006-2011* (October 2006).
[13] Texas House of Representatives, House Bill 1973, 80th Legislature, 2007.

In 2005, the 79th Legislature enacted House Bill 2420 requiring the Texas Health and Human Services Commission (HHSC) to consider using Medicaid funds for Graduate Medical Education reimbursement to support the training of resident physicians in accredited public university residency programs that provide clinical training in federally-qualified health centers and hospitals near the Mexico border serving patients in a rural area.[14] Only Valley Baptist Hospital in Harlingen met these criteria.

Telemedicine

Use of telemedicine is one way to ensure access to needed specialists in areas impacted by a health care professional shortage. Videoconferencing enables an urban provider to talk to a rural patient and her local provider to discuss diagnoses, treatment options, and patient concerns, eliminating the need for burdensome travel by patients who live in remote areas. Senate Bill 1340, from the 79th legislative session, directed HHSC to perform a study on the use of telemedicine within the Texas Medicaid program.[15] HHSC's report noted that Texas Medicaid reimburses hub site or local providers for consultation or interpretation services, but that it will not reimburse them for direct patient services as part of a telemedicine visit.[16] Senate Bill 24 from the 80th legislative session attempted to rectify some of these disparities, directing HHSC to create rules that would allow for the reimbursement of telemedicine services to both the hub site and consulting physician.[17] It also extended the period of a telemedicine pilot program to

[14] Texas House of Representatives, House Bill 2420, 79th Legislature, 2005.
[15] Texas Senate. Senate Bill 1340, 79th Legislature, 2005.
[16] Health and Human Services Commission, *Telemedicine in Texas Medicaid* (January 2006), at 1.
[17] Texas Senate, Senate Bill 24, 80th Legislature, 2007.

September 2009. Senate Bill 760, passed in 2007, directed HHSC to encourage providers to use telemedicine services to expand access to care.[18]

Nursing Initiatives

In 2007, the 80th Legislature made strides to alleviate the nursing shortage situation. It built upon work from the previous session. Senate Bill 132, from the 79th legislative session, created tuition exemptions, loan programs, and grant programs. Some of the grant programs used funds to identify, develop, and implement innovative methods to make the most effective use of limited professional nursing program faculty and other resources. The bill also encouraged the use of grants under the professional nursing shortage reduction program to assist nursing programs in the education, recruitment and retention of faculty.[19] Senate Bill 132 also required the Higher Education Coordinating Board to set a target goal for nursing school graduation and make recommendations to meet that goal. The report, released in November 2006, called for a four-fold increase in graduates of initial entry nursing programs by 2020 to meet demand, which is expected to rise by 86 percent between by that date. The report recommends tying additional funding with accountability measures for the nursing educational programs involved and states that other measures to maintain the nursing workforce must also be considered, including encouraging nurses to delay retirement, improving the workplace, and ensuring competitive wages are offered. [20]

[18] Texas Senate, Senate Bill 760, 80th Legislature, 2007.
[19] Texas Senate, Senate Bill 132, 79th Legislature, 2005.
[20] Center for Nursing Workforce Studies, Texas Department of State Health Services Center for Health Statistics, and the Statewide Health Coordinating Council's Texas Center for Nursing Workforce Studies Advisory Committee, *The Supply of and Demand for Registered Nurses and Nurse Graduates in Texas*, Publication No. 25-12514 (November 1, 2006).

The Coordinating Board's report on student completion rates in initial RN programs showed a 56 percent completion rate within two years of starting an initial RN program and is indicated that financial concerns drive many of these students to take on part- or full-time work, which could hinder their educational progress. Work-study programs and financial aid were discussed as a means of combating the financial issues that hinder some nursing students. Faculty needs were also cited as a problem, with the Coordinating Board finding that nursing programs need to increase full-time faculty by 54 percent to meet expected nursing needs by 2010.[21]

Much of the nursing legislation passed by the 80th Legislature expanded on the initiatives created by SB 132. Senate Bill 289 further encouraged the HECB to use grant funds to increase the number of nursing faculty. House Bill 3443 created the nurse education partnership grant program, which provides grants to hospital nursing programs that encourage clinical skills and encourage students to continue with their nursing educations. Senate Bill 139 required the HECB to study ways to improve the curricula of vocational nursing programs. Senate Bill 138 required the Board of Nursing to develop rules to promote the retention and graduation of nursing students and to recognize programs with a graduation rate of at least 85 percent.

Finally, Senate Bill 993 mandated the creation of nursing peer review committees and patient safety committees at all facilities and establishments that employed 10 or more nurses. SB 993 streamlined and clarified provisions on reporting to make it easier for

[21] Higher Education Coordinating Board, *Strategies for Increasing Student Completion Rates in Initial RN Licensure Programs* (October 2006).

nurses and the institutions in which they practice to know when to report, thus making the practice of nursing safer and better for nurses and for patients.

Loan Repayment Programs

The Texas Higher Education Coordinating Council administers two key health-related loan repayment programs - the Physician Education Loan Repayment Program (PELRP) and the Dental Education Loan Repayment Program (DELRP).

PELRP was authorized by the legislature in 1985 to address the need for more primary care physicians. Under this program, physicians may receive a maximum of $9,000[22] per year in loan repayment for a maximum of five years in exchange for providing primary care services in a state-recommended HPSA or by working for the Department of State Health Services, Texas Department of Criminal Justice, or Texas Youth Commission. Additional loan repayment assistance is available for physicians in PELRP who meet stricter federal standards. No money is distributed to PELRP physicians until at least one year of service has been provided. In 2008, 68 physicians were participating in the program. [23]

DELRP was authorized by the legislature in 1999 to address dental shortages. General and pediatric dentists may receive $10,000 per year in loan repayment in exchange for practicing in dental HPSAs. Dentists who also meet federal requirements - two years of

[22] The Texas Higher Education Coordinating Board is considering a recommendation to increase the amount to $13,000 per year.
[23] Texas Higher Education Coordinating Board, *Staff Response to Legislative Request for Information, Follow-up questions on the current and long-range needs of the healthcare workforce*, October 8, 2008.

service and practice in a public or non-profit facility - may receive up to $20,000 per year toward their educational loans. In 2008, 16 dentists were participating in DELRP.[24]

Physician Shortages

Physician shortages are a concern, not just in Texas, but nationwide. The Council on Graduate Medical Education predicts that there will be a nationwide shortage of 96,000 physicians in the U.S. by 2020.[25] In order to address the coming shortage, the Council recommends that medical schools increase enrollment by 15 percent between 2002 and 2012.[26] This is particularly important in Texas where the two factors of stagnant capacity in medical schools over the past 20 years and a growing population work to create a potential crisis.

A 2003 survey by the U.S. Department of Health and Human Services indicated that there were 175 physicians practicing in Texas for every 100,000 people, as compared to the rest of the nation where 278 physicians practiced for every 100,000 people.[27] While some of the discrepancy may be due to the physical size of Texas and its proximity to the Mexico border, other border states had an average physician to population ratio of 219 physicians for every 100,000 people.[28] The difference between Texas and the other the U.S.-Mexico border states demonstrates that Texas' workforce problems are fundamentally different from the rest of the nation and that its workforce problems are

[24] *Ibid*.
[25] Council on Graduate Medical Education, *Physician Workforce Policy Guidelines for the United States, 2000-2020*, at 18, (January 2005), Available: http://www.cogme.gov/16.pdf, Accessed: November 2008.
[26] Ibid, at 19.
[27] Health Resources and Services Administration, Border County Health Workforce Profiles: Texas, *Health Professions - Physicians, Dentists and Registered Nurses*, Available: http://bhpr.hrsa.gov/healthworkforce/border/texas/healthprofessions.htm, Accessed: November 2008.
[28] *Ibid*.

much more severe. In 2008, 27 Texas counties did not have a primary care physician, and 16 counties had only one primary care physician.[29] Current shortages are felt largely in rural areas, where only nine percent of U.S. physicians practice even though 17 percent of the population lives in rural areas.[30] Particularly severe are rural shortages of obstetricians and mental health professionals.[31]

Primary Care Physician Shortage

The general term primary care physician includes those trained in one of six specialties: family practice, general practice, internal medicine, obstetrics and/ or gynecology, general pediatrics, and geriatrics.[32] Due the rapid growth of the state's population, Texas will see increases in the demand for physician specialists who treat both ends of the age spectrum. By 2020 the under-18 population is projected to increase to almost 7.5 million children.[33] Currently there are 48.4 pediatricians for every 100,000 children in Texas, compared to a national ratio of 64 pediatricians for every 100,000 children.[34] At the other end of the age spectrum, the rise in the aging population will lead to an increased need for geriatricians. In 2007, Texas had only 31 physicians with a primary specialty in geriatrics and 256 with a secondary specialty in geriatrics.[35] Texas has only seven

[29] Supra note 1.
[30] *Ibid*.
[31] *Ibid*.
[32] Department of State Health Services, Center for Health Statistics, *Promoting Excellence Through Healthcare Workforce Planning in Texas* - 2007, Publication No. 25-12901 (February 2008), at 5.
[33] Texas State Demographer, Texas Population Estimates "Projected Growth in the Number of Children Under 18 years of Age," Available: http://www.txsdc.utsa.edu/tpepp/2006projections, Accessed: November 2008.
[34] American Board of Pediatrics, "Ratio of General Pediatricians per 100,000 Children 0-18 Years of Age," https://www.abatorg/ABPWebSite/stats/wrkfrc/workforce%2007-08.pdf, Accessed: November 2008.
[35] Department of State Health Services, Center for Health Statistics, *Promoting Excellence Through Healthcare Workforce Planning in Texas* - 2007, Publication No. 25-12901 (February 2008), at 8.

geriatric medicine fellowship programs, which were training 15 residents during the 2005-2006 academic year.[36]

In addition to Texas' supply of primary care physicians lagging behind that of the rest of the U.S., the state faces its own supply inequity within its borders. While 13 percent of Texas' population lives in the 177 rural counties, only 10 percent of the state's physicians practice in these counties.[37] The lowest physician supply ratios exist in the 32 border counties, West Texas, and South Texas. The statewide ratio of physicians is 67.9 physicians per 100,000 people. The ratio of primary care physicians per population was highest in the urban non-border counties (72.2) and lowest in the rural border counties (36.1). However, most physicians practicing in rural counties were primary care physicians. Urban counties have a higher proportion of specialists.[38]

The Council on Graduate Medical Education has recommended that medical schools increase enrollment by 15 percent between 2002 and 2012. This is especially important in Texas, where medical school capacity has remained constant over the past 20 years. In 2007, only 47.1 percent of the primary care physicians practicing in Texas were graduates of Texas Medical schools.[39] To compensate for the impending need for more physicians, medical schools in Texas have announced the plans to increase their class sizes.

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[36] *Ibid*, at 4.
[37] *Ibid*, at 5
[38] *Ibid*, at 8.
[39] *Ibid*, at 6.

Another issue with maintaining the physician workforce in Texas is the size of the state's graduate medical education program. Research has demonstrated a strong correlation between the location where a physician completes his graduate medical training and where he will practice. In 2004, 56.9 percent of Texas medical school graduates planned to stay in Texas to complete their training. An additional 38 percent would have preferred to stay in Texas but did not because of the lack of availability of training slots.[40]

Nurses

Background

The nursing shortage, which both the nation and Texas are experiencing, is probably the most publicized health care workforce shortage and Both the United States and Texas are in the midst of a nursing shortage. The estimates suggest that the U.S. is deficient by over 100,000 nurses today and the U.S. Bureau of Labor Statistics estimates that the nursing shortfall will reach 1 million by 2020.[41] The current Texas hospital nursing vacancy rate is 12 percent,[42]

Registered Nurses

In 2007, there were 155,858 active registered nurses (RNs) practicing in Texas, with 86.5 percent working full-time and 13.5 percent part-time. While this number of RNs gives Texas a supply ratio of 656.6 RNs per 100,000 residents, up from 628.6 in 2005, this

[40] *Ibid*, at 6.
[41] National Conference of State Legislatures, *Health People, Strong Communities: Strategies for Improving Rural Health and Strengthening the Local Economy* (November 2005), at 11.
[42] Supra note 30.

ratio remains significantly lower than the national average rate of 825 RNs per 100,000.[43] While the entire state faces nursing shortages, some areas are disproportionately affected. Metropolitan counties consistently have a higher ratio of nurses than rural counties. Border counties have lower supply ratios than the rest of Texas, but the rates of RNs in these counties are increasing at a rate comparable to the rest of the state.

One factor that contributes to Texas' nursing shortage is a lack of sufficient numbers of faculty in Texas RN licensure and education programs, which must deny admittance to a substantial number of qualified nursing applicants in part because there are not enough faculty to teach classes.[44] This means that the number of new RN graduates is unlikely to alleviate shortages. Texas schools of nursing are unable to keep pace with the growing demand for nurses and the aging of the workforce. In 2007, only 3,616 RNs who held active licenses to practice in Texas were employed as nurse faculty or educators.[45] The median age of these nurse faculty and educators was 55 years and the nurse faculty to student ratio is capped at 1 faculty member to 10 students.[46] This situation leaves Texas nursing schools at a definite disadvantage in their ability to expand the capacity of their nursing schools.

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[43] Supra note 1.
[44] Department of State Health Services, Center for Nursing Workforce Studies, *Highlights: The Supply of Registered Nurses in Texas – 2005*, (November 2006), at 6.
[45] *Ibid*, at 22.
[46] Texas Board of Nursing, *Education Frequently Asked Questions - Faculty*, Available: http://www.bne.state.tx.us/nursingeducation/faq_faculty.html, Accessed: November 2008.

Other factors include RNs retiring and leaving the field. The median age of Texas RNs in 2007 was 47 years; the median age for border counties was 43, and 49 for rural counties.[47] The national median age for RNs was 43 years.

Licensed Vocational Nurses

Licensed vocational nurses (LVNs) provide nursing care under the supervision of an RN or a physician. In 2007, there were 65,230 LVNs in active practice in Texas, creating a supply ratio of 274.9 per 100,000 population, Texas licensed vocational nurse ratios actually exceed the national average (around 130 LVNs per 100,000). Statewide ratios for LVNs are significantly higher in rural counties than in metropolitan counties: rural border counties have an average of 293.3 LVNs 100,000 people and rural non-border counties have a ratio of 467.9 LVNs. LVNs are often relied upon in rural areas where RN shortages are prevalent.[48]

Advanced Practice Nurses

The term advanced practice nurse encompasses nurse practitioners, nurse midwives, certified registered nurse anesthetists, and clinical nurse specialists.[49] Nurse practitioners practice under their own authority as nurses and in collaboration with physicians to provide such services as prescribing medications. Texas had 4,858 practicing nurse practitioners in 2007. The Texas supply ratio of nurse practitioners has been lower than the national average for years. The highest nurse practitioner supply ratios in the state are in Panhandle and West-Central Texas counties. Most of the counties without a nurse

[47] Supra note 33, at 21.
[48] *Ibid,* at 26.
[49] *Ibid*, at 22.

practitioner are in South Texas. Metropolitan counties consistently have a higher ratio of nurse practitioners than rural counties.[50]

In Texas, there are two types of midwives: certified nurse midwives and direct-entry midwives. Certified nurse-midwives are RNs who provide gynecological and obstetrical care for women during pregnancy, childbirth, and the post-partum period. Certified nurse-midwives are regulated by the Texas Board of Nurse Examiners. Direct-entry midwives are not RNs but complete a midwifery course and pass a state-approved examination required by the Texas Midwifery Board. In 2007, Texas had 248 certified nurse-midwives who were located largely in metropolitan areas of the state. The Texas supply ratio of 5.1 certified nurse-midwives per 100,000 women of childbearing age is less than half that of the national ratio and 11.6 nationally.[51]

A Certified Registered Nurse Anesthetist (CRNA) is an RN who, through advanced training and experience and completion of a national examination, acquires the right to administer anesthesia. They also provide anesthesia related care before and after surgical and therapeutic procedures, pain management, and emergency services, such as airway management. Texas had 1,922 practicing CRNAs in 2007. The ratio of CRNAs was 4.6 per 100,000 in the border counties in 2003, which was substantially lower than the overall state ratio of 6.9, which has increased by 28.6 percent between 2000 and 2007.[52]

[50] *Ibid*, at 23.
[51] *Ibid,* at 24.
[52] *Ibid*, at 25.

Clinical nurse specialists are advanced practice nurses with graduate education who specialize in clinical interventions in disease and illness. In 2007 there were only 1,198 clinical nurse specialists in Texas and most located largely in metropolitan areas.[53] Their ratios decreased by 38.9 percent between 2000 and 2007.

Dentists

Nationally, the number of dentists per population has been dropping in recent years, and the American Dental Association and Health Resources and Services Administration estimate that by 2020 there will be only 53 active dentists per 100,000 people. This ratio is down from a peak of 60 dentists per 100,000 in 1990.[54] In 2007, there were 8,671 dentists practicing in Texas, with a supply ratio of 36.5 per 100,000 people, significantly behind the national average of about 46.[55] Metropolitan regions of the state have far more dentists than rural regions, 38.5 and 23.5 respectively. Texas has 82 whole county dental health profession shortage areas and 49 counties have no dentists at all; the majority of these are in the Border region and in West Texas. However, the supply ratio of dentists in border counties is far short of those of the rest of the state: metropolitan border counties have a ratio of 15.7 dentists and rural border counties have a ratio of 11.8 dentists.

Dental Hygienists

Dental hygienists perform dental services under the supervision of their supervising dentist and are eligible for licensure after the successful completion of a 2-4 year

[53] *Ibid*.
[54] *Ibid*. at 27.
[55] *Ibid*.

program. There were 9,188 dental hygienists practicing in Texas in 2007. Because dental hygienists typically practice under the supervision of dentists, their geographic distribution mirrors that of dentists. There are, therefore, more dental hygienists in metropolitan regions in the state, lower supply ratios in rural regions, and some of the lowest supply ratios in the border region. Supply ratios for dental hygienists have been increasing in Texas since 1981, but are still lower than the national average.[56]

Mental Health Professionals

Background

Mental health professional shortages exist for the vast majority of Texas counties; over 70 percent of Texas counties are designated as whole county mental health care provider shortage areas.[57] These shortages limit people's ability to seek appropriate diagnoses and appropriate and timely care.

Psychiatrists

Psychiatrists are the physician practitioners in the mental health field. They provide a full range of mental health services, including diagnosis and talk and drug therapies. In 2007, there were 1,510 general psychiatrists and 192 child psychiatrists in Texas. Psychiatrist shortages are particularly extreme in rural and border areas, where residents must depend largely on state mental health/mental retardation facilities in order to find needed providers.[58] This shortage is expected to continue to grow as the state's population grows because the number of psychiatry residency positions in Texas has

[56] *Ibid*, at 29.
[57] *Ibid,* at 37.
[58] *Ibid*, at 36.

remained the same for the past 10 years and the median age of psychiatrists is 54, rising from 52.9 in 2005.[59] The supply ratios for psychiatrists are generally the largest in the metropolitan counties; however, metropolitan border counties had the lowest ratios in the state.

Psychologists

Psychologists diagnose and treat mental health issues, but cannot prescribe medications in Texas. The Board of Examiners of Psychologists licenses four types of psychological providers - licensed psychologists, provisionally licensed psychologists, licensed specialists in school psychology, and licensed psychological associates.[60] Licensed psychologists have doctorate degrees in psychology and are authorized to practice independently. Provisionally licensed psychologists have doctorate degrees but must be supervised. The licensed psychological associate license is a master's degree license, and such practitioners must have their practices supervised. Licensed specialists in school psychology may practice independently in public schools after one year of supervised practice; the license requires completion of a school psychology training program or a master's degree in psychology with relevant course work.[61]

A psychologist may hold more than one of these licenses: in 2007, there were 5,942 unduplicated licensed psychologists statewide. Licensed psychologists made up the bulk of the licensees in 2007. Psychologist supply ratios have been relatively steady in Texas

[59] *Ibid*.
[60] *Ibid*, at 37.
[61] *Ibid*, at 38.

since 1999, with a supply ratio of around 25 psychologists per 100,000 people. One hundred and eight counties did not have a psychologist.[62]

Social Workers

Social workers diagnose and treat mental conditions through therapy.[63] The Department of State Health Services issues four types of social work licenses in Texas: Licensed Clinical Social Workers, Licensed Master Social Workers, Licensed Master Social Workers-Advanced Practitioners, and Licensed Baccalaureate Social Workers.[64] In 2007, there were 15,743 social workers in Texas. Metropolitan counties had much higher ratios than rural counties 37 of which did not have any social workers.[65] The ratio of social workers has been fairly consistent for the past nine years, but there has been a slight decline in the magnitude of the ratio due to population growth.

Licensed Professional Counselors

The Department of State Health Services licenses professional counselors, who use counseling, assessment, consulting, and referral to help facilitate human development and adjustment throughout the life span.[66] In 2007, there were 13,967 licensed professional counselors statewide up from 10,896 in 2005. However, the increase in licensees is due to a new methodology that includes interns as licensed professional counselors. The inclusion of interns has also affected the median age of professional counselors, which not including interns, is 53; with interns included the median age is 51 years.

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[62] *Ibid*.
[63] *Ibid*, at 39.
[64] *Ibid*.
[65] *Ibid*.
[66] *Ibid*, at 40.

Metropolitan counties had much higher ratios of licensed professional counselors than rural counties. Rural border counties had the lowest ratio. There were 47 counties that had no licensed professional counselors.[67]

Allied Health Professions

Allied health professionals work as part of the health care team to assist in health care delivery. Allied health professions are clinical health care professions, distinct from medicine and nursing, which work in partnership with almost all facets of health care. From disease prevention to chronic illness management to the promotion of healthy lifestyles, diagnosing diseases and infections, and providing therapy - an adequate supply of allied health professionals can be an important resource in providing care, especially in underserved areas. While Texas may lag behind the rest of the nation in terms of supply of other health care professions, in some of the allied health professions Texas is at or above national averages. However, supply of such professionals in the rural and border regions of Texas still lags behind the rest of the state.

Clinical Laboratory Scientists

Clinical laboratory scientists analyze tissues, cells, and fluids, to determine the presence, extent, or absence of disease. These tests provide the medical data needed to evaluate the effectiveness of treatment. A designation as a clinical laboratory technologist requires a bachelor's degree in medical technology or life sciences; clinical laboratory technicians usually need an associate degree or a certificate. The majority of clinical laboratory scientists are employed in hospitals; the remaining jobs were in medical and diagnostic

[67] *Ibid*.

laboratories and physicians' offices. Employment in clinical laboratory sciences is expected to increase 14 percent in the next decade; however, most jobs will continue to be in hospitals.[68] Most employers prefer clinical laboratory scientists to be certified or licensed. Texas does not license, certify, or register clinical laboratory scientists.

Medical Radiologic Technologists

Medical Radiologic Technologists administer x rays and nonradioactive materials into patients' bloodstreams for diagnostic purposes under the direction of a physician or nurse. While Texas' supply ratio consistently lagged behind the U.S. during the 1990s, it began to rise dramatically around 2002. In 2007, the ratio in Texas is 81 MRTs per 100,000 people, about that of the national ratio. The ratio is highest in urban counties, lower in rural counties, and lowest in the border counties.[69]

Occupational Therapists

Occupational therapists use activities and therapeutic techniques to treat and rehabilitate physically, cognitively, and emotionally disabled people. There were 5,729 occupational therapists practicing in Texas in 2007. The state's ratios were higher than the national average in the late 1990s. The ratios were highest in urban non-border counties and much lowest in rural border counties of the state.[70]

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[68] U.S. Department of Labor Bureau of Labor Statistics, *Occupational Outlook Handbook, 2008-09 Edition Clinical Laboratory Technologists and Technicians*, Available: http://www.bls.gov/oco/ocos096.htm, Accessed: November 2008.
[69] Supra note 33, at 30.
[70] *Ibid*, at 31.

Optometrists

Optometrists are health care providers who focus on the diagnosis, management and treatment of eye diseases and disorders. During the past decade, Texas' ratios of optometrists have recently approached that of the rest of the nation, about 12 per 100,000 people. In 2007, there were 2,668 optometrists practicing in Texas. Now, optometrists are more likely to practice in urban areas; however, prior to 1984 the ratios for optometrists were higher in rural areas.[71]

Pharmacists

The state ratio of pharmacists per population exceeded the national ratio in 2002, the last year Health Resources and Services Administration date was available. As with many other health care professions, ratios are highest in urban non-border counties and lowest in rural border counties.[72]

Physical Therapists

Physical Therapists provide services to individuals to develop maintain and restore movement and function where movement and function are threatened by aging, injury, disease, or environmental factors. A master's degree is the only entry level physical therapy degree; there are no bachelor's programs in physical therapy in the U.S. Texas requires physical therapists to hold a master's degree in an accredited physical therapy program and pass a national examination. The supply ratio of physical therapists statewide has consistently lagged behind that of the U.S. and the growth rate of this

[71] *Ibid*, at 32.
[72] Texas Department of State Health Services, Center for Health Statistics, *Promoting Excellence Through Healthcare Workforce Planning in Texas* - 2007, Publication No. 25-12901 (February 2008), at 33.

profession has decreased within the state in the last few years. There were 9,240 physical therapists practicing in Texas in 2007. Supply ratios are generally highest in urban counties and lowest in rural border counties.[73]

Physician Assistants

Physician assistants practice medicine under the supervision of physicians and receive formal training to provide diagnostic, therapeutic, and preventive health care services. Working as members of the health care team, they take medical histories, examine and treat patients, order and interpret laboratory tests and x rays, make diagnoses and treat minor injuries, by suturing, splinting, and casting. In rural and underserved areas, physician assistants may be the principal care providers where a physician is present for only one or two days each week.[74] In 2003, Texas had 2,125 physician assistants, but only 378 physician assistants practiced within 100 miles of the border. Texas' ratio of physician assistant to population was 9.6, substantially lower than the national average of 14.8 and the average of the other states that border Mexico, 12.9.[75]

Respiratory Care Practitioners

Respiratory care therapists evaluate, treat, and care for patients with breathing and cardiopulmonary disorders under the direction of a physician. The Texas Department of State Health Services issues licenses to respiratory therapists who have graduated from an accredited respiratory care program and have passed a national examination. In 2007,

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[73] *Ibid*, at 34.
[74] U.S. Department of Labor Bureau of Labor Statistics, *Occupational Outlook Handbook, 2008-09 Edition Physician Assistants*, Available: http://www.bls.gov/oco/ocos081.htm, Accessed: November 2008.
[75] Health Resources and Services Administration, *Tables for Profiles of Non-Physician Clinicians*, Available: http://bhpr.hrsa.gov/healthworkforce/border/texas/nonclintables.htm, Accessed: November 2008.

there were 11,666 respiratory care therapists in Texas. Urban areas of the state had higher ratios of respiratory therapists and rural areas had lower areas. Unfortunately, the gap between urban and rural regions is increasing. In 2007, there were 56 counties with no respiratory therapists; most of these were in West Texas, South Texas, and the Panhandle.[76]

Public Health

A shortage of public health workers nationwide has wide ranging implications effecting health care concerns ranging from disaster preparedness to day-to-day health. The Association of Schools of Public Health (ASPH) estimates that the nation will need an additional 250,000 public health workers by 2020. Considering that Texas currently comprises about eight percent of the U.S. population, the state will need at least 20,000 more public health workers in the next decade to keep pace with its public health needs.[77] Any continued shortage of public health workers could severely impact Texas, with its ethnically diverse population, international borders, major shipping ports, and two major international airports. The public health issues in Texas encompass not just day-to-day health maintenance, but also larger scale epidemiological and public health disease preparedness.

In addition to the public health worker shortage, the ASPH "Statement on the Public Health Workforce" concludes that there is a demonstrated racial and ethnic disparity in

[76] Supra note 73, at 35.
[77] Association of Schools of Public Health, *Confronting the Public Health Workforce Crisis: ASPH Statement on the Public Health Workforce*, Available: http://www.asph.org/UserFiles/PHWFShortage0208.pdf, Accessed: November 2008.

the public health workforce, which effects parity and geographic mal-distribution. The report states that the current public health worker corps does not resemble the diverse populations that they serve and the fact that the nation's health professions have not kept pace with changing demographics may be an even greater cause of disparities in health access and outcomes than the persistent lack of health insurance for tens of millions of Americans.[78]

Conclusion

If Texas does not deal with the current health profession workforce trends, the workforce shortage will worsen. The current health professions workforce shortage is especially acute in rural, border, and underserved inner-city areas, but it affects the entire state. Problems with access to health care services have the potential to impact not just our health, but also health insurance costs, productivity, and the economy. Ultimately, Texas needs a comprehensive approach to dealing with the shortage that tackles the many facets of this very difficult and challenging problem.

[78] *Ibid*.

Select Border Focus

The first section of this joint interim report covers medically "underserved" areas of the state in general. The findings and recommendations stemming from the first section by design are applicable to the border region since it is one of Texas' medically underserved areas. This second section of the joint interim report highlights certain critical health care professional shortages that are found within the border region and which were covered in the May 28 joint hearing held by the Senate's Health and Human Services and the International Relations and Trade Committees.

Overview: Physician Ratios & Population Growth

Focusing on the border region, both Committees were informed at their joint hearing that the physician supply along the border region is disproportionately low when compared to state and national ratios.[79] The President of the University of Texas Health Science Center at San Antonio, Dr. Francisco G. Cigarroa, testified that "nationally, there exists an average of 266 physicians per 100,000 people. In South Texas, there are only 113 doctors for 100,000 people."[80]

These findings become even more of a concern when the expected population growth of the border region is taken into account. Testimony indicated that the population growth

[79] Dr. Leonel Vela, Lower Rio Grande Valley Regional Academic Health Center, *Testimony before the Senate Committees on Health and Human Services and on International Relations and Trade*, (Austin, TX, May 28, 2008).
[80] Dr. Francisco G. Cigarroa, The University of Texas Health Science Center at San Antonio, *Testimony before the Senate Committees on Health and Human Services and on International Relations and Trade*, (Austin, TX, May 28, 2008).

in Texas increased "at twice the rate of the U.S. population in general."[81] However, by some accounts, while the state is projected to grow by nearly 68% between the years 2000 and 2040, the five major counties along the immediate border region (Cameron, El Paso, Hidalgo, Maverick, Starr and Webb) are projected to have more than a 110% growth between the same years.[82] Additionally, testimony indicated that "the Rio Grande Valley is one of the fastest growing areas in the United States and is one of the poorest areas in Texas and the country."[83] In terms of sheer number growth in the immediate next 20 years, the Rio Grande Valley (RGV) which is composed of Cameron, Hidalgo, Starr and Willacy counties, is projected to nearly double in size. Both Committees were informed that "according to projections, the total number of people in the RGV is projected to grow 21 percent by 2010, 51 percent by 2020, and 83 percent by 2030 to an estimated total of 1.9 million people, nearly double the current population."[84]

As mentioned above, along the border region, the ratio of physicians to population is of grave concern especially when it is seen in light of national and state ratios. The Texas Higher Education Coordinating Board reported to both Committees several key findings on the shortage of physicians that justify such a conclusion. In correspondence to the Committees, the Higher Education Commissioner, Dr. Raymund A. Parades, explained that according to some estimates, while the national average of physician to resident ratio is 196 to 100,000 and the state ratio is 158 to 100,000, the ratio in South Texas is only 112 physicians to 100,000 residents. Specifically for the Upper Rio Grande, the shortage

[81] Dr. Ben G. Raimer, Statewide Health Coordinating Council, *Testimony before the Senate Committees on Health and Human Services and on International Relations and Trade*, (Austin, TX, May 28, 2008).
[82] Senate Committee on International Relations and Trade, *Interim Report 78th Legislative Interim*.
[83] James Springfield, Valley Baptist Health System, *Testimony before the Senate Committees on Health and Human Services and on International Relations and Trade*, (Austin, TX, May 28, 2008).
[84] *Ibid.*

of physicians amounts to a dismal ratio of 106 physicians to 100,000 residents.[85] The President and CEO of Valley Baptist Health System, James Springfield, testified that "the Harlingen and McAllen hospital referral regions have the lowest and second lowest number of physicians per 100,000 population in the entire nation and is federally designated as a 'medically underserved area.'"[86] Consequently, the Committees were informed that the Rio Grande Valley "is the nation's most medically underserved region" while it is "one of the fastest growing areas in the United States."[87]

Cigarroa set the foundation for both Committees of why the health disparities along the border and South Texas need to be addressed by the state. He testified that "the health care disparities that are experienced in South Texas have resulted in serious public health issues. These challenges are not just the challenges of this region of the country, or even of just Texas, but they are challenges that impact our entire nation."[88] The problem for underserved regions along the border, such as the RGV, is that they are also distressed regions of the state. Dr. Ben G. Raimer, Chair of the Texas Statewide Health Coordinating Council, reported to the Committees that of the 32 border counties within 62 miles of the Texas-Mexico border "in 2005, 17 of the 32 counties had 27.8% to 45.7% of their population living in poverty" whereas the Texas mean was 17.5% and the U.S. mean was 13.3%.[89] In terms of the Lower Rio Grande Valley, both Committees were informed that "the Rio Grande Valley is one of the poorest areas in Texas and the

[85] Dr. Raymund A. Paredes, Texas Higher Education Coordinating Board, *Correspondence to International Relations and Trade Committee*, May 21, 2008, *Written testimony submitted to the Senate Committees on Health and Human Services and on International Relations and Trade*, (Austin, TX, May 28, 2008).
[86] Supra note 83.
[87] *Ibid.*
[88] Supra note 80.
[89] Supra note 81.

country. Among the 349 MSAs in the United States, the MSA encompassing Hidalgo County has the lowest per capita income level. The MSA encompassing Cameron County has the third lowest per capita personal income level in the country."[90] For regions like the Lower Rio Grande Valley that have high population growth, low physician to patient ratios and economies that are among the most distressed in the nation, the impact of the lack of health care access is a realistic problem for the state and nation. Springfield testified that "the Rio Grande Valley has a 37.1% uninsured population with another 18% of the population reliant on the Medicaid program. There is a definite link between the lack of health care coverage and decreased access to health care services. The uninsured are more likely to be hospitalized for conditions that might have been avoided with timely, preventative care."[91] In terms of the uninsured levels for the remainder of the border region, Raimer informed the Committees that "11 counties along the Texas-Mexico Border have disproportionately high uninsured number[s] (Cameron, Dimmitt, Hidalgo, Kinney, Maverick, Starr, Val Verde, Webb, Willacy, Zapata, and Zavala)" and that "34.6% of Texas-Mexico border counties population are uninsured, 10% higher than Texas' average, in 2003."[92]

Health Care Access: Lack of Medical Infrastructure

Along the border the inability to increase the physician patient ratio can be attributed to several factors with the main one being the lack of medical infrastructure. Springfield explained to the Committees that a confluence of factors "including per capita income, a high proportion of uninsured, indigent and Medicaid residents, low population density

[90] Supra note 83.
[91] *Ibid.*
[92] Supra note 81.

and a geographically remote border region has made it difficult to recruit and retain physicians in the Valley."[93] Springfield reported, "but in my humble opinion, the single more important reason behind the Valley's inability to recruit and retain physicians lies in the fact that until recently, the Valley lacked an academic medical infrastructure. This left us without the ability to cultivate 'home-grown, home-town' physicians"[94]

It was only until 1997, when the Regional Academic Health Center (RAHC) was established, that there were clinical opportunities available to third and fourth year medical students and residents. However, these medical opportunities are limited due to the fact that there are only two residency programs: family practice and internal medicine. Each residency requires over three years of work and there are only five residency positions available per year, for a total of fifteen positions for both internal medicine and family practice.[95]

Although the establishment of the RAHC has made a positive impact and is beginning to address the need for additional physicians, the lack of medical infrastructure curtails the Valley's ability to retain and recruit needed physicians to the region. The Dean of the RAHC, Dr. Leonel Vela, informed both Committees that "currently, over 40% of the graduates of Texas medical schools leave the state to pursue residency training. This is an important consideration in addressing physician supply concerns in Texas because physicians tend to practice in the general vicinity of where they train. Therefore, once new medical school graduates leave the state for their residency training, the probability

[93] Supra note 83.
[94] *Ibid.*
[95] Supra note 80.

of them eventually practicing in Texas is greatly reduced. . .since the Valley Border area has a very limited number of residency slots, the opportunities to recruit locally trained physicians are quite limited."[96] While discussing the lack of medical infrastructure, limited residency slots and the current and expected population growth, Vela concluded that "the result is that the pool of physicians available to recruit to the Border does not appear to be increasing sufficiently to meet the needs of this region; and, in fact, the pool appears to be shrinking relative to the population growth and escalating health care needs."[97]

Enhancing the pool of physicians available to recruit to the border and to other underserved areas is critical because of the inherent consequences that result from the lack of a sufficient physician supply. The Committees were informed that "the consequences that are inherent with the lack of comparability in physician supply are aggravated by the health disparities, significant population growth and socioeconomic realities that exist in this border region. Health disparities include diseases like tuberculosis, cancers of the cervix, liver, gallbladder and stomach; diabetes, and obesity – conditions for which regrettably the South Texas Border Region has disproportionately higher rates than the rest of the state."[98]

As illustrated above, not only does the border have a higher population growth rate, it finds itself with a greater need for physicians due to the severe medical needs found within the region, as well as the lack of medical infrastructure. According to the

[96] Supra note 79.
[97] *Ibid.*
[98] *Ibid.*

testimony presented "the Valley Border area has some distinct disadvantages when it comes to recruiting physicians in the face of this competitive environment. . . one distinct disadvantage is that there are a very small number of residency positions in the Valley. This means that unlike regions of comparable size, the Valley border region, with a population of 1.2 million people, does not have a breadth of residency training programs that is commensurate with the size and needs of its population."[99] In other words, health disparities, significant population growth and the economics of the area lead to higher rates of disease disproportionate to the rest of the state and region's lack of medical infrastructure prohibits it from adequately addressing these unique challenges. Health experts testifying repeatedly explained to both Committees that a medical school in the Lower Rio Grande Valley was a viable and critical part of the solution to address the health care needs of South Texas.

Increasing Physician Supply: Lower Valley Medical School

Dr. Joe Stafford, Assistant Commissioner for Academic Affairs and Research Division at the Texas Higher Education Coordinating Board, reported to both Committees that "the population base in the Valley certainly is large enough to fully justify the establishment of a new medical school."[100] This key assessment was echoed by the President of the University of Texas Health Science Center-San Antonio, Dr. Francisco G. Cigarroa, who agreed with Dr. Stafford's conclusion. He said, "my belief is consistent with the Coordinating Board's finding that the population of South Texas not only where it is today but also through the projections given by our state demographer basically

[99] *Ibid.*
[100] Dr. Joe Stafford, Texas Higher Education Coordinating Board, *Testimony before the Senate Committees on Health and Human Services and on International Relations and Trade*, (Austin, TX, May 28, 2008).

legitimately justify the need for a new school of medicine in the South Texas region."[101] The Dean of the School of Health Science at the University of Texas-Brownsville, Dr. Eldon Nelson, while discussing the health disparities of the border region and the lack of medical infrastructure in the Lower Rio Grande Valley urged the Committees that "to meet the extraordinary needs for health care professionals [in] the Lower Rio Grande Valley, it is time to bring a full attention to the growing disparate health needs of our citizens…among the poorest in the nation. It is time our leaders commit to provide a full-service Health Science Center and four-year Medical School for the deserving people of the Lower Rio Grande Valley!"[102] Springfield also testified that providing the Valley the ability to cultivate "home-grown, home-town physicians" through a medical school and additional resources will make the difference between continuing the severe shortage of physicians while not keeping pace with the unprecedented population growth and meeting the demand with the necessary health care resources.[103] More recently, the Coordinating Board arrived at a similar conclusion in their *Projecting the Need for Medical Education in Texas Study* that with a medical school in the Valley "students from the local and surrounding communities would have greater opportunities to attend medical school and would likely remain or return to the area to practice."[104]

Additional Resources: GME, Incentive & Pipeline Programs

Health experts testified that in order to address the health care needs of medically underserved areas, such as the border region, a variety of additional resources must be

[101] Supra note 80.
[102] Dr. Eldon Nelson, University of Texas-Brownsville. *Testimony before the Senate Committees on Health and Human Services and on International Relations and Trade*. (Austin, TX, May 28, 2008).
[103] Supra note 83.
[104] Texas Higher Education Coordinating Board, *Projecting the need for Medical Education in Texas Study*, Available: http://www.thecb.state.tx.us/reports/pdf/0494.pdf, Accessed: November 2008.

provided – from increased Graduate Medical Education (GME) funding to expanding pipeline programs – to help regions recruit and train residents into the medical field.

Springfield informed the Committees that "the Balance[d] Budget Act of 1997 placed national caps on the number of residency positions that are eligible for Medicare GME funding purposes. These caps significantly constrain hospitals in rapidly growing, medically underserved areas from developing and participating in training programs that will provide access for patients."[105] This action severely impacted areas of the state similar to the border region. Springfield explains, "in our case, this action severely limits the potential for the RAHC to address the critical physician shortage…."[106] Financially, for the Lower Rio Grande Valley, this resulted in a loss of approximately $800,000 to Valley Baptist Health System, which jeopardizes the financing of new graduate medical education programs or resident training programs.[107] Unfortunately, the Committees were reminded that the Lower Rio Grande Valley does not have a true publicly funded hospital to address these needs. Testimony given stated that "it is important to note here that there are no publicly funded or state funded hospitals in the region to serve patients or train residents. In fact, the closest public hospitals are in San Antonio or Galveston; well over 250 and 300 miles away respectively."[108] As a consequence, "Valley Baptist Medical Centers in Harlingen and Brownsville serve as the safety net hospitals for indigent care and Medicaid patients and Valley Baptist Harlingen is the primary teaching

[105] Supra note 83.
[106] *Ibid.*
[107] *Ibid.*
[108] *Ibid.*

hospital in the region."[109] Investment by the state in GME funding and lifting the caps in areas the state designates as physician shortage areas, such as the Lower Rio Grande Valley, will increase the number of residency programs and will help recruit new physicians to these areas.

Addressing GME Needs

During the 78th Legislative Session, in 2003, the state cut $40 million in state-supported Medicaid GME funding, which had the consequence of a reduction of $54 million in federal matching funds. Almost $100 million in GME funding for Texas hospitals and Texas medical schools were cut, which resulted in a loss of residency slots and training programs.[110]

The Chairs of HHSC and IRT asked the Texas Higher Education Coordinating Board for additional information on the current and long-range needs of the health care workforce. In response to the question as to how should the Coordinating Board's recommendation to fund 250 additional GME spots be allocated among the types of residency programs, THECB said that all "existing residency programs should be encouraged to add additional residents if they have the capacity and support from the Accreditation Council on Graduate Medical Education and their affiliated teaching hospital. Residency programs that offer first-year positions should be encouraged to increase the number of residents in training and this should be a top priority…additionally, residency programs

[109] *Ibid.*
[110] *Ibid.*

that offer specializations in the areas of geriatrics, pediatric sub-specialties, surgery, and orthopedic surgery should also be encouraged to increase in size."[111]

The Coordinating Board also stated that residency programs must offer residents the opportunity to fulfill the educational requirements of the particular specialty. These requirements vary by program length, teaching/supervising faculty ratios, facilities, and number of cases. An example offered was that a pediatric surgical residency program must document that residents are participating in a sufficient number and type of surgical procedures (at least 1,200 procedures) per year. All residency programs in all specialties should be encouraged to increase available slots, yet priority should be given to the first-year entering residency positions. Texas medical school graduates would have a greater opportunity to remain in Texas during their residency education through this type of approach.[112]

House Bill 2420 - 79th Legislative Session

In 2005, during the 79th Legislative Session, House Bill 2420 was enacted and required the "development of a separate formula for Graduate Medical Education reimbursement to support the training of resident physicians in an accredited residency program with a primary field of allopathic or osteopathic medicine meeting certain criteria, including being sponsored by or affiliated with a public university, providing clinical training in federally-qualified health centers and in hospitals near the Mexico border serving patients

[111] Higher Education Coordinating Board, *Staff Response to Legislative Request for Information, Follow-up questions on the current and long-range needs of the healthcare workforce*, October 8, 2008.
[112] *Ibid.*

in a rural area."[113] However, this bill received no funding and has had no salutary effect. It is suggested that if the Medicaid GME program funding were restored, it would help teaching hospitals to offset the costs of training residents and supporting residents' salaries, as well as maintain training capacity.[114] Increasing residency program capacity by funding Medicaid GME would also "ensure we do not export our medical school graduates unnecessarily to other states for training."[115]

Recruitment Incentives

Another question addressed by THECB was the cost to enhance or create loan repayment and scholarship programs for physicians and dentists. The "scholarship" programs introduced during the last several legislative sessions entail a service obligation. Under these programs, recipients must sign promissory notes whereby the scholarship becomes a loan if the service obligation is not fulfilled. In order to address this type of arrangement rather than a scholarship with no service obligation, Coordinating Board staff recommends a different approach based on past experience.[116] Under the most recent Sunset legislation, the Coordinating Board requires existing loan forgiveness programs be converted to loan repayment programs that include completion of service before disbursement of loan repayment. This requirement helps ensure that limited state funds are expended for the purpose intended. Payment before service is less efficient and

[113] Senate Research Center, *Bill Analysis for House Bill 2420,* Statement of Intent. May 17, 2005.
[114] Bryan Sperry, Children's Hospital Association of Texas, *Written testimony submitted to the Senate Committees on Health and Human Services and International Relations and Trade*, (Austin, TX, May 28, 2008).
[115] *Ibid.*
[116] *Ibid.*

more costly because all of the business processes required for a new loan program must be in place to track recipients over a period of years. [117]

Enhancing the "Pipeline"

Several solutions proposed for the lack of physicians are focused on enhancing the "pipeline," that is, "the further development and funding of programs that engender student interest in medicine…providing these students opportunities in their high school and undergraduate years that will prepare them for acceptance to, and successful completion of, medical school."[118] These programs have proven to be successful in that the number of students from the border area pursuing medical careers has increased.[119]

Raimer provided several recommendations to both Committees that would expand and sustain the health care workforce through pipeline programs. He recommended to the Committees that the pool of health care professionals could be expanded by "utilizing K-12 health career promotions" and by providing "scholarships and loan programs that are attractive to disadvantaged student participants."[120] Dr. Nancy W. Dickey, President of the Texas A&M Health Science Center echoed Raimer's testimony. Dickey testified that in order to address the health care professional shortage the state should "install pipeline and 'early college' programs to increase college readiness and consideration of health careers and provide start-up funding for new professional programs."[121]

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[117] *Ibid.*
[118] Supra note 79.
[119] *Ibid.*
[120] Supra note 81.
[121] Dr. Nancy W. Dickey, Texas A&M Health Science Center, *Testimony before the Senate Committees on Health and Human Services and on International Relations and Trade*, (Austin, TX, May 28, 2008).

Other Issues: Nursing & Dental Health Care Shortages

A number of other health care shortages were reported to both Committees and are covered in the general portion of this joint report. However, a couple of glaring shortage rates along the border region merit special attention.

For instance, the Coordinating Board informed both Committees that while the statewide average of nurses is 626 to 100,000 residents, the South Texas region has an average of 438 nurses for 100,000 residents.[122] For non-border rural areas, the ratio is 465 to 100,000 while for border rural areas it is 225.[123] Dr. Eileen T. Breslin, Dean of the School of Nursing at the University of Texas Health Science Center at San Antonio reported as of May 12, 2008, non-border metropolitan regions in Texas had 715.2 active registered nurses per 100,000 population whereas border metropolitan regions had 468.9 nurses per 100,000. Texas non-border, non-metropolitan regions of Texas, had a ratio of 465.1 to 100,000 whereas border non-metropolitan regions had a ratio of only 224.5 to 100,000.[124] Dr. Mary Jane Hamilton, Dean of the College of Nursing and Health Sciences at Texas A&M University-Corpus Christi, echoed these findings when she testified that "it is well known that our region and the border area have a deficit of registered nurses, baccalaureate and advanced practice nurses."[125] Hamilton reported that although "the national ratio of registered nurses to population is 1:750, in South Texas, the numbers are frequently half that level. Therefore, South Texas patients are less likely

[122] Supra note 85.
[123] Supra note 81.
[124] Dr. Eileen T. Breslin, School of Nursing at the University of Texas Health Science Center, *Testimony before the Senate Committees on Health and Human Services and on International Relations and Trade*, (Austin, TX, May 28, 2008).
[125] Dr. Mary Jane Hamilton, College of Nursing and Health Sciences at Texas A&M University-Corpus Christi, *Testimony before the Senate Committees on Health and Human Services and on International Relations and Trade*, (Austin, TX, May 28, 2008).

to receive care from a registered nurse in an acute care agency."[126] Hamilton concluded that the "higher acuity patients plus fewer nurses to care for them is a prescription for danger. Lack of registered nurses has been associated with unanticipated events that result in death, injury or permanent loss of function."[127] To address these nursing shortages in underserved areas, the Committees were informed that the state needs to hire adequately prepared faculty for schools in shortage areas; increase recruitment of students in rural and underserved areas; provide better financial support for students; and, design flexible and creative program that meet the needs of students and faculty in underserved regions.[128]

In terms of dental health professional shortages, Cigarroa reported that "the U.S. Department of Health and Human Services notes that the dentist-to-population ratio for the Texas/Mexico border area is 75% below the state and national averages."[129] Specifically, Raimer reported that while the Texas dentist provider to 100,000 population ratio for Texas was 36.5 to 100,000 and non-border urban areas was 41.1 to 100,000, for border urban areas it was 15.7 to 100,000. In terms of non-border rural areas of Texas, the ratio was 25.2 per 100,000 while the border rural ratio was 11.8. Clearly, the border has significantly lower ratios of general dentists than the rest of the state. Along the border and in other underserved areas, the affordability of dental care is a barrier to access by patients. Dental hygienists have been actively working to expand their scope of

[126] *Ibid.*
[127] *Ibid.*
[128] *Ibid.*
[129] Supra note 80.

practice and reduce their supervision requirements to offset the lack of accessibility.[130] Diseases such as periodontal disease and oral cancer hit indigent and minority populations at higher rates, "especially along the U.S./Mexico border" and it is estimated that 20% of people have over 80% of dental diseases.[131]

To address the ratio of dentists to patients, the Committees were advised that incentives need to be created for dental schools "to partner with CHC's [community health centers] and local health departments to increase training programs along the border."[132] Additionally, the state needs to focus on prevention, such as working with schools and promotoras (Community Health Workers), to lay foundations for quality preventative care.[133] Lastly, the Committees were informed that such an emphasis on dental hygienists and their use as a possible primary source of preventative dental care would have a salutary effect on overall accessibility of dental care.[134]

Conclusion

The health professions shortage along the border region is of great concern. Being one of the fastest growing regions in the state, the border has a disproportionately high number of uninsured residents and a disproportionate low number of health care professionals. The lack of medical infrastructure in the Lower Rio Grande Valley, in particular, poses serious challenges in trying to address the need for health professionals. Health and

[130] Marilyn Harrington, UT Health Science Center at San Antonio, *Testimony before the Senate Committees on Health and Human Services and on International Relations and Trade*, (Austin, TX, May 28, 2008).
[131] Juanita Lozano-Pineda, UT Health Science Center San Antonio. *Testimony before the Senate Committees on Health and Human Services and on International Relations and Trade*, (Austin, TX, May 28, 2008).
[132] *Ibid.*
[133] *Ibid.*
[134] Supra note 130.

higher education experts repeatedly explained that the 1.2 million population base of the Valley justifies the establishment of a new medical school as a critical part to a comprehensive approach to address the unique needs of this region.

Recommendations

1. **Enhance health professional loan forgiveness programs and target them to underserved communities, also consider providing tax credits (mortgages and loans), or tuition waivers.**

   Rationale: Pursuing the necessary education to become a health professional can be an expensive task and leave students with large amounts of debt, which can limit students' choices of work environment and location. Expanding loan repayment programs will allow more students from disadvantaged backgrounds to pursue health education without the concerns of overwhelming debt and create incentives for professionals to work in underserved areas.

2. **Increase Medicaid physician reimbursement rates.**

   Rationale: Physicians who provide care for Medicaid patients typically practice in underserved areas. Increasing their reimbursement rates could attract more physicians to those areas.

3. **Provide Texas Medical Board with adequate funding to process backlog of physician license requests.**

Rationale: HB1973 directed the Texas Medical Board to ensure that the average time to process a license application does not exceed 51 days and to give priority to applicants who plan to practice in underserved areas. The changes have resulted in a reduction in the licensure time.

4. **Incentivize providers to serve in underserved areas, including discounted Locum tenens services for rural physicians who wish to pursue CME courses, use of ORCA community development funds to build practices in rural areas, and mechanisms to participate in continuing education courses, i.e. through AHEC**

   Rationale: Incentives are needed to address the mal-distribution of health professionals and ensure that Texas citizens have access to quality health care no matter where they choose to live within the state.

5. **HPSA's should have ready access to telemedicine, electronic records, and other tools that improve access and workforce efficiency.**

   Rationale: Multidisciplinary tools used across geographic regions could increase access to care in underserved areas.

6. **Promote "creative" retirement and "second career" options that permit health professionals to continue to work in part time positions.**

   Rationale: Secondary career health professionals may have the income and flexibility to provide care in underserved areas.

7. **Create specialized/certified programs for workers in niches such as nursing homes, correctional facilities, and state schools.**

   Rationale: Programs concentrating on niche health care fields will allow schools and students to focus on the skills most necessary to provide care for those areas.

8. **Continue to expand medical school enrollment.**

   Rationale: The expanding population of Texas coupled with the static medical school enrollment, is one reason why Texas continues to be medically underserved.

9. **Develop, expand, and fund pipeline programs between high schools, universities, and health science centers--assure recruitment of students by utilizing K-12 health career promotions such as T-STEM, JAMP, AHEC.**

   Rationale: Encouraging children to enter into science and health careers when they are young will increase the probability that they will enter these careers and will return to their underserved areas to practice.

10. **Measure the effectiveness of pipeline programs and create best practices that can be shared with communities and health science centers.**

    Rationale: To ensure that pipeline programs are effective, the state needs to develop mechanisms to determine best practices.

11. **Restore Medicaid GME funding to pre-FY 02-03 levels with adjustments for inflationary costs.**

    Rationale: Medicaid GME funding is one way of expanding medical residency programs and Texas physicians tend to practice within 100 miles of where they completed their residencies.

12. **Increase the number of funded GME spots in Texas.**

    Rationale: This is a cost-effective way of increasing the physician workforce in Texas because physicians tend to practice within 100 miles of where they complete their residencies.

13. **Expand the five core residencies in any medical school: psychiatry, OB/GYN, general surgery, internal medicine, family practice.**

    Rationale: Texas is especially underserved in primary care physicians. Expanding the five core residencies will ensure that we train more physicians who can treat primary care issues.

14. **Encourage colleges and universities to use technology to provide access to course for health professions students, including distance learning, web-based courses, tutorials, and use of joint or rotating faculty.**

    Rationale: Allowing more distance or non-traditional learning formats expands health professional education to those in rural areas, at-home parents, those seeking a second career and others who can not attend daytime

classes at a local university or health science center. Expanding the pool of potential health professional students will increase the workforce supply and diversity within the health care professions.

15. Adopt a state model for projecting future health profession supply and demand to facilitate appropriate planning

Rationale: Ensuring our state better predict workforce shortages will enable us to plan and address workforce issues. Only with sufficient information can we truly comprehend and address any workforce issues in Texas.

16. Emphasize qualifications and licensure of laboratory personnel.

Rationale: To ensure that laboratory personnel provide quality services standardization of duties and licensure is necessary.

17. Expand tele-psychiatry services for underserved areas, especially geriatrics and child/adolescent services.

Rationale: Texas has a shortage of mental health professionals. The use of tele-psychiatry will improve access to mental health services in underserved areas.

18. Expand nursing faculty education programs--provide the resources to stimulate nurse education programs at the 2-year and 4-year levels.

Rationale: Nursing faculty education programs need to expand in order to increase enrollment at nursing schools.

19. Expand mechanisms to improve infrastructure for nursing schools and increase nursing faculty positions

Rationale: Nursing schools have too few faculty members to expand enrollment. Because the population of Texas has grown while nursing school enrollment has not grown at the same pace, is one reason why Texas continues to be medically underserved.

20. Fund basic science courses that combine students from medical school, allied health science schools, and nursing schools on the same campus, or from remote campuses utilizing distance education technologies.

Rationale: Interdisciplinary education programs have the potential to improve the quality of health education and health care outcomes in practice settings.

21. Seriously consider the expansion of the Regional Academic Health Center into a four-year medical school to expand the medical infrastructure of the Lower Rio Grande Valley/Border region.

Rationale: As higher educational and health professionals have reported to the committees, having a medical school in the Lower Rio Grande Valley will allow students from local and surrounding communities greater

opportunities to attend medical school and to remain in their home community to practice. This medical school will make the difference between continuing the severe shortage of physicians and meeting the demand for health care professionals.

Mental Health and Traumatic Brain Injury Services for Returning Veterans

Upon the request of Senator Shapleigh, the Senate Committee on Health and Human Services discussed issues of mental health and traumatic brain injury services for returning veterans during the October 13, 2008 hearing. Recognizing that veterans' mental health is a complex issue involving many entities from federal to state to local, the Committee invited the Department of State Health Services (DSHS) and Texas Veterans Commission (TVC) to testify about the types of services available to veterans in Texas. The Department of Assistive and Rehabilitative Services (DARS) submitted written testimony and had a witness available.

Services from the Department of State Health Services

As part of the SAMHSA Mental Health Transformation Grant, the Transformation Workgroup established a workgroup with a focus on veterans' mental health services on August 5, 2008. The workgroup is composed of representatives from the Governor's office, Health and Human Services Commission (HHSC), DSHS, Texas Military Forces, TVC, Texas Workforce Commission, Texas Council of Community MH/MH Centers, Texas Association of Community Health Centers, and family member representation. The workgroup held meetings in September and October where they reviewed needs, services, and gaps. The workgroup concluded that veterans face:

1. disparities between the quality of services between service providers,
2. gaps in the accessibility of services,

3. gaps in the coordination and communication of services, and
4. stigma and fear about accessing services.

The veterans' workgroup also concluded that impacted family members have very little access to benefits. The workgroup was mindful of SB 1058, 80th legislative session, which directed the relevant agencies to develop a referral program to provide referrals to service members for reintegration services and a directory of services and other resources, tools, and counseling programs available to aid veterans and their immediate families in the reintegration process. The workgroup has crafted preliminary recommendations:

1. support Texas Military Forces and Texas Veterans Commission requests for dedicated eligibility workers and case management staff
2. facilitate access to eligibility information by laypersons
3. provide training to peers and other connectors
4. provide evidence-based treatment training to practitioners

The veterans' workgroup and the Transformation Workgroup members contributed information to DSHS about the veterans' mental health services available at their organizations. DSHS expects to publish its report "Behavioral Health Services for Returning Veterans and Their Families: Services, Gaps, and Recommendations" in December 2008.

Services from the Texas Veterans Commission

The Texas Veterans Commission (TVC) does not provide direct health care services, but assists veterans in obtaining services from the U.S. Department of Veterans Affairs (VA)

and other agencies. Veterans may receive health care services and care for traumatic brain injury, post traumatic stress disorder, substance abuse, and other mental health issues from VA medical centers. Once a veteran is deemed eligible, he or she qualifies for inpatient and outpatient care. Eligibility is generally determined through a verification of discharge, length of service, and financial status. Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans receive VA medical coverage for 5 years after termination of active duty service. Spouses of OIF and OEF veterans can also receive medical care from VA medical centers. The TVC has included an exceptional item request for the 81st legislative session to institute a peer support program to assist veterans in eligibility inquiries.

Services from the Department of Assistive and Rehabilitative Services

The Department of Assistive and Rehabilitative Services (DARS) has programs available to veterans, including the Comprehensive Rehabilitation Services Program, the Vocational Rehabilitation Program, and the Independent Living Services and Centers Program. All United States veterans may apply for any of DARS services. During state fiscal year 2008, DARS served 43 veterans in the comprehensive rehabilitation program, 4,160 veterans in the vocational rehabilitation program, and 138 veterans in the independent living program. Recently, DARS finalized an agreement with the VA to improve the work and independent living opportunities for veterans and avoid duplication of services.

Conclusion

Recognizing that veterans' mental health is a complex issue involving many entities from federal to state to local, agencies and entities that deal with veterans' health and mental health care must work in a coordinated collaborative process to provide services.

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ROBERT L. NICHOLS
STATE SENATOR

December 12, 2008

The Honorable Jane Nelson
Chairwoman, Senate Health and Human Services Committee
Texas Senate

Dear Senator Nelson:

Thank you for your leadership of the Senate Committee on Health and Human Services. I am pleased to sign the interim report and endorse its recommendations.

I also offer the following recommendations to complement the report:

- In developing a long-term plan to decrease the wait time for Medicaid 1915(c) waiver services, the state should consider prioritizing needs versus wants, using objective criteria including crisis and emergency situations and considering whether an individual is already receiving waiver services. (Charge #1, Recommendation #1, page 28)
- Texas should not divert funds away from existing mental health services to fund silo transportation programs that can only be accessed through participation in other programs. More coordination among existing transportation services within HHSC is needed before funding new transportation programs. (Charge #3, Recommendation #4, page 75 and Recommendation #9, page 76).
- Texas should not mandate additional coverage requirements for health insurance, even for the purchase of vaccines (Charge #7, Recommendation #14, page 185).
- The average annual cost per consumer in 3 and 4 bed HCS residential programs is more costly than the 6-bed ICF/MR model. DADS should authorize HCS residential providers up to 13 beds, instead of only 3 and 4 beds. DADS should also eliminate the requirement to have at least one awake staff in the 4 bed model.

Again, thank you for your dedicated leadership. I look forward to our work in the 81st Legislative Session.

Sincerely,

Robert Lee Nichols

Robert L. Nichols
State Senator

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The Senate of The State of Texas

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Senator Royce West
District 23

President Pro Tempore
2006

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December 15, 2008

Honorable Jane Nelson
Chair
Texas Senate Committee on Health and Human Services
Sam Houston State Office Building, Room 420
Austin, TX 78701

Dear Madame Chair:

Thank you for your work and that of your staff over this past interim in examining the charges given to the committee by the lieutenant governor and producing the interim report.

I agree with the great majority of the 109 recommendations in the report. However, for the reasons given below I do not endorse Recommendation 1, Charge 1, Recommendation 5, Charge 4, Recommendation 7, Charge 5, or Recommendation 14, Charge 5. Accordingly, I ask that you publish this letter as part of the report.

Recommendation 1, Charge 1

The recommendation itself, to "(d)evelop a long range plan to decrease the wait time for Medicaid 1915(c) waiver services," is commendable. The "rationale" for the recommendation, however, contains the following statement: "(t)he Legislature should review and amend the entitlement and waiver residential settings and eligibility criteria." How does the committee propose to amend the settings and eligibility criteria? This is simply too open-ended to endorse.

Recommendation 5, Charge 4

There is no basis in the report for the recommendation to "(c)ontinue supporting the case management pilot to privatize case management services in 5% of cases." The conclusory statements found on page 91 and in the "rationale" for the recommendation regarding child placement agencies having higher retention rates are undocumented.

Recommendation 7, Charge 5

My reluctance to support this recommendation - to "fund the cost of (foster) care" - stems from its potential impact on kinship care, a topic which was regrettably omitted from the recommendations.

In the committee's hearing on April 30, 2008, we established that kinship care is less expensive than foster care, and results in better outcomes for the children. In the discussion of kinship care on pages 101-102, the interim report finds: **(1)** that placement with kin "often provides a more stable and less psychologically harmful environment than placement with strangers"; **(2)** that limited financial resources are often the reason kin are unable to care for a child; and **(3)** that kin have a hard time meeting the licensing requirements of foster care required to receive greater assistance.

Despite this, the report makes no recommendation on kinship care, other than to increase privatization (*see* Recommendation 14). Furthermore, while the passage of HR 6893 is probably too recent to be incorporated into the report, it does make federal money available to increase kinship placements. This money, however, is only available if the state puts up a match and the potential kin parents meet certain safety-related licensing requirements for an undetermined amount of time. I am concerned that by spending more on *foster* care, without identifying a source of money to make use of the new federal *kinship* care legislation, we will preclude ourselves from taking advantage of this new opportunity.

Recommendation 14, Charge 5

I do not agree with this recommendation, to "(c)ontinue to support the case management pilot and increase the pilot to 10%, including family-based safety services and kinship care programs," simply because I think we should wait for funding and implementation of the previously approved 5% pilot before expanding its size.

Again, thank you for work in developing this comprehensive document, and thank you for your consideration of the concerns I have outlined above.

Sincerely,

Honorable Royce West
State Senator, District 23

RW/glk

Chair, Higher Education Subcommittee
Vice Chair, Finance
Legislative Budget Board

Judith Zaffirini
State Senator, District 21
President Pro Tempore, 1997

Committees
Administration
Education
Health and Human Services

December 16, 2008

Senator Jane Nelson, Chair
Senate Health and Human Services Committee
Texas Legislature
Austin, Texas 78711

Dear Chair Nelson:

Thank you for your leadership as Chair of the Senate Health and Human Services Committee. It is my privilege to serve with you, and I appreciate the opportunity to share my perspective regarding the Committee's interim report. Because the report includes many fine recommendations that could improve the quality of health and human services for Texans, I am delighted to sign it, provided that this letter is included. It reflects some of my concerns:

First, while the recommendation regarding a long-term plan to decrease the wait time for 1915 (c) waiver services is laudable, the rationale suggests revising eligibility criteria so that fewer persons are eligible for services. Because the only way to reduce the wait time is to increase funding and because the report does not address concerns related to current entitlements and eligibility, the recommendation is too vague and sweeping without a review in developing a plan.

Second, the purpose of Resiliency Disease Management (RDM) was to ensure that persons would receive the most appropriate services to move them into recovery and out of the public system. Changing the target priority population by limiting the number of adults who can receive on-going services to those who have a diagnosis of Schizophrenia, Bi-Polar Disorder, or Major Depression would not achieve the promise of RDM. Persons who do not have one of the three diagnoses cannot access on-going services without a clinical override in the RDM system by

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the community mental health center, causing them to cycle in and out of crisis, often ending up in the criminal justice or state hospital system. While the intent of RDM is to manage an underfunded service delivery system with better outcomes, the methodology is flawed. The targeted priority population should be based on a person's functioning level and not based on diagnoses, especially because the state serves only less than 25 percent of the documented need. What's more, had consumers and advocates been invited to testify, that information might have been presented to the committee and included in the report.

Finally, the report states that private child placing agencies (CPAs) have a higher caseworker retention rate than the state. To my knowledge, CPAs never have demonstrated higher retention. What's more, this unsubstantiated claim is used not only to support the case management pilot project to privatize five percent of cases, but also to increase it to 10 percent. With our track record of privatizing the state's functions, a more prudent approach would be to study the outcomes of the original pilot project before calling for an expansion. What's more, there is no rationale provided for co-locating state regulators with CPAs, and recommending that the state not lease the cheapest best space, but instead lease space with a predefined entity violates the state's normal purchasing process. What's more, placing regulators in the same place as the entities they are regulating would create a conflict of interest.

Count on my continued leadership to ensure that every Texan has access to quality health and human services. I look forward to our continued productive relationship during the 2009 Texas Legislative Session. May God bless you.

Very truly yours,

Judith Zaffirini

Judith Zaffirini

JZ/jr

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December 17, 2008

The Honorable Jane Nelson
Chair
Senate Committee on Health and Human Services
Capitol, Room 1E.3

Dear Chairwoman Nelson:

After review of the proposed Senate Committee on Health and Human Services Interim Report, I decided to add my signature to the document. Although there are many recommendations that I strongly support in the report, I am concerned about the implications of several others.

As a whole, there are several improvements to existing programs that were recommended in the report, which I wholeheartedly support. Adult Stem Cell research, for instance, could help improve the health of Texans who face serious conditions like cancer. I also appreciate the recommendations that could improve the administration of Medicaid and support the state's developmentally disabled citizens. However, I am concerned that several committee recommendations will increase the fiscal burdens on state and local government.

As you know, Health and Human Services, accounts for 31.6% of appropriations in the 2008-2009 biennial budget, or approximately $53 billion. Funding for Article II has steadily increased each biennium and there are no indications that the demands will decrease in the years ahead. Although Texas is in a better financial situation than most other states, our economic future may not be as positive. I am also concerned about increasing the number of health-related mandates. This includes nutrition mandates on school districts that are already struggling for resources, as well as additional mandates on foster parents, of which we have a short-supply.

Thank you for your leadership and hard work during the interim. I look forward to continuing our work together as we continue to make health and human services a state function that efficiently empowers Texans.

May God bless,

DP/st

The Senate of
The State of Texas

December 19, 2008

The Honorable Jane Nelson
Chairwoman
Senate Committee on Health & Human Services

VIA HAND DELIVERY

RE: Senate Committee on Health & Human Services' Interim Report

Dear Chairwoman Nelson:

We appreciate your leadership and the Committee's work on the Senate Health and Human Services Committee's Interim Report for the 81st session of the Texas Legislature.

However, the Interim Report does not accurately chronicle the health care crisis in Texas today. The chart below highlights key health-related statistics in Texas:

Texas' Health Care: A 50 State Comparison

Measurement	**Texas' Ranking** (50th = lowest, 1st = highest)
Percentage of population with health insurance	50th
Percentage of children with health insurance	50th
Percentage of poor covered by Medicaid	41st
Percentage of adults with employer-based health insurance	48th
Number of diabetes deaths per 100,000 population	9th
Teen birth rate per 1,000 population	1st
Percentage of children who are immunized	41st
Obesity rate	3rd
Mental health expenditure per capita	48th
Percentage who visited dentist/dental clinic within past year	43rd

Source: The Henry J. Kaiser Family Foundation, available at: www.statehealthfacts.org.

P.O. Box 12068, State Capitol, Austin, Texas 78711

Lack of health insurance, lack of sufficient health care professionals, and inadequate access to health care affect more and more Texans each day, especially during a nationwide economic crisis. These issues must be addressed in the upcoming legislative session.

Our top priorities for the 81st legislative session include:

- expanding CHIP coverage,
- restoring 12-month continuous enrollment for Medicaid enrollees,
- increasing employer-sponsored health insurance,
- increasing the number of health care professionals in medically underserved areas throughout the state, and
- strengthening mental health services for returning soldiers and their families.

To more accurately reflect the facts in our great state, we ask that you attach the following as an Addendum to the Senate Committee on Health & Human Services' Interim Report. In this Addendum, you will find comments specifically relating to:

- Charge 1 (Intellectual and Developmental Disabilities),
- Charge 2 (Medicaid Outcome-Based Reimbursement),
- Charge 3 (Resiliency and Disease Management),
- Charge 4 (CPS Caseworkers and Caseloads),
- Charge 7 (Wellness),
- Joint Charge 2 (Health Care Workforce), and
- Mental Health and Traumatic Brain Injury Services for Returning Veterans (the final section of the Committee's Interim Report),

With this Addendum, we sign the Committee's Interim Report to demonstrate that we stand together to work on important health issues in the 81st Session.

Very truly yours,

Elliot Shapleigh

Judith Zaffirini

Roy W. Y

Carlos Uresti

cc: Lt. Gov. David Dewhurst

Charge 1: Intellectual and Developmental Disabilities

Department of Justice investigation

Although the Interim Report mentions the Department of Justice investigation, we feel it is necessary to include more detail. On March 15, 2005, the Department of Justice (DOJ) notified the Department of Aging and Disability Services (DADS) of their intent to initiate a Civil Rights of Institutionalized Persons Act (CRIPA) investigation of Lubbock State School (Lubbock). The DOJ released the letter of findings regarding Lubbock on December 11, 2006. On March 11, 2008, the DOJ notified DADS of their intent to expand their CRIPA investigation to Denton State School (Denton). Five months later, on August 20, 2008, the DOJ notified DADS that they would expand the investigation to include the remaining state schools.

After the Lubbock investigation, the DOJ found that Lubbock:

> *substantially departed from generally accepted professional standards of care in its failure to: protect residents from harm; provide adequate behavioral services; provide freedom from unnecessary or inappropriate restraints; provide adequate habilitation; provide adequate medical care (including psychiatric services, general medical care, pharmacy services, dental care, occupation and physical therapy, and physical and nutritional management); and provide services in the most integrated setting appropriate to their needs.*[1]

On December 1, 2008, the DOJ released their letter of findings for the remaining twelve state schools. The DOJ concluded that:

> *numerous conditions and practices at the Facilities violate the constitutional and federal statutory rights of residents. In particular, ... the Facilities fail to provide consumers with adequate: (A) protection from harm; (B) training and associated behavioral and mental health services; (C) health care, including nutritional and physical management; (D) integrated supports and services and planning; and (E) discharge planning and placement in the most integrated setting.*

The DOJ's most recent letter signifies that the serious problems found at Lubbock are not unique to one state school and indicative of systemic issues. The DOJ attributes these systemic issues to high staff attrition and vacancy rates for direct care staff and clinical professionals. In fact, since Fiscal Year 2004, DADS has suspended or fired more than 800 employees for abusing residents. Until DADS can successfully retain, train and supervise their staff, we can not begin to address the problems and deficiencies identified by the DOJ.

Herein below are highlights from the most recent letter of findings:

[1] Determining whether treatment is adequate focuses on whether institutional conditions substantially depart from generally accepted professional judgment, practices or standards. Further, residents have the right to be treated in the most integrated setting appropriate to meet their individualized needs.

I. Protection from Harm: The state has a responsibility to protect consumers in its care from harm. However, nursing and direct care staffing shortages and high staff turnover rates keep facilities from identifying risk and preventing foreseeable harm. The DOJ found that the frequency and severity of critical incidents are disturbingly high and often directly related to insufficient staffing.

A. Incidents and Injuries - Pica

1. Parents and DADS staff frequently point to pica, the craving or ingestion of non-food items, as one of those conditions for which a person requires institutional care. The DOJ made several important points:

   a. The staff often do not witness the pica incident and discover the incidents only *after* the consumer has health complications or the foreign object is found in their stool (e.g., latex gloves, Swiss Army knives).

   b. DADS does not have a uniform system for tracking pica incidents to ensure that residents' behavior plans and medical plans are appropriately updated.

   c. DADS does not have a uniform system to safeguard items likely to be ingested.

2. High rates of pica reflect weaknesses in DADS' behavioral supports that expose residents to significant harm.

B. Restraints - DOJ found fault with the liberal use, type and purpose of restraints used in the Texas system. Restraints should be used in emergencies only, not as a part of a resident's behavior plan.

1. From January through September 2008, a total of 10,143 restraints were applied to 751 consumers. Despite DADS' efforts to train staff to utilize restraints on a less frequent basis, the DOJ found that the use of restraints actually increased in some facilities.

2. Mechanical restraints are regarded as the most restrictive type of restraint and increasingly forbidden by a growing number of providers. Despite this national trend, mechanical restraints account for a high percentage of all restraints used in Texas.

3. The DOJ's report details broken bones, black eyes and a death, which resulted from restraints.

4. The DOJ made the following recommendations:

   a. all facilities cease immediately the use of prone holds and straitjackets,

   b. eliminate "as needed" or "standing orders" for restrictive controls,

   c. limit the use of mechanical restraints to emergencies only,

   d. use only the least restrictive restraint techniques, and

   e. conduct an administrative review after all restraints. Currently, facilities only conduct restraint debriefings on emergency restraints, which account for only one to five percent of all restraints. Failing to conduct thorough restraint debriefings renders any reduction effort meaningless.

5. The facilities' Human Rights Committee's responsibility includes withholding approval for a requested restrictive procedure until an adequate understanding of the reasons for and lack of alternatives to such procedures can be established, but the DOJ was clear that this is not happening in Texas.

6. Failure to coordinate communication services with behavioral supports also contributes to the high use of restraints.

7. The DOJ recommends that state schools develop a system to analyze and monitor the use of "pro re nata" (PRN; as needed) medications. PRN medications also can be referred to as chemical restraints.

C. Abuse and Neglect Reporting - In a departure from generally accepted professional standards, facilities provide a wide range of employees access to the names of alleged perpetrators, witnesses' names, and nature of the allegations. The DOJ stated that the facilities must cease the practice of discussing investigations in any meeting not comprised solely of staff essential to the investigatory process to ensure the integrity of the reporting and investigation process.

II. Health Care

A. The DOJ is concerned about the high mortality rates among persons in state schools. .

1. 114 consumers died between September 2007 and September 2008.

2. At least 53 deaths were related to aspiration, pneumonia, respiratory failure, sepsis, bowel obstruction, or failure to thrive. Generally, the aforementioned are preventable conditions that often are the result of lapses in care or failure to put medical interventions in place in a timely manner.

B. DOJ attributed much of the medical health issues to lack of staff, both nursing and direct care. Also staffs from the various disciplines are not communicating adequately, such that physician's orders are not followed and staff are not alerted to watch for reactions when a consumer's medication is modified.

1. Consumers are injured on a regular basis by one another—4,837 times in a three-month time span. Thus, on average, 52 incidents of peer aggression occurred per day.

2. A significant number of consumers are hospitalized due to nutritional management issues. The meal cards used to identify necessary supports are too superficial. In addition, the staff do not adhere to these instructions, and consumers are allowed access to foods that are not part of their meal plans.

3. Some medically fragile consumers were not transferred to hospitals in a timely manner.

C. Among the most disturbing issues detailed in the report is that many consumers receive psychotropic medication with no diagnosis at all or are identified as having a "Mental Disorder, Not Otherwise Specified" (NOS).

1. The DOJ found that the quality of psychiatric diagnosis falls far below professionally accepted standards.

2. The absence of adequate behavioral assessments to identify the causes of maladaptive behaviors has helped make this misuse of psychotropic medications possible.

   a. 78 percent of those with maladaptive behaviors receive psychotropic medications regularly. Many often receive multiple medications for the same condition.

   b. The DOJ described this as an unusually high percentage and found no clinical justification for the rates.

3. The DOJ recommends that the state perform a thorough psychiatric work up of all consumers, and

a. provide a clinically justifiable current diagnosis for each person;

b. remove all diagnoses that cannot be clinically justified; and

c. ensure that all medications are appropriate and specifically matched to the current, clinically justified diagnoses.

D. Behavior programs and habilitation are used to address significant behavior problems and assist consumers to live in more integrated settings. Lack of adequate behavior programs result in problems with pica, restraints, unjustified psychotropic medication, and other bad outcomes for consumers.

1. 71 percent of consumers engage in maladaptive behaviors.

2. This high rate indicates that behavioral supports and services suffer from major deficiencies, and that persons are at risk of harm as a result.

3. Across the board, assessments were found lacking (e.g., behavioral, pain, psychiatric). The types of assessments were inadequate and those that were used often were left incomplete or done inappropriately.

4. Without adequate assessment, there is no way to implement appropriate behavioral treatment plans.

5. Maladaptive behaviors

   a. The DOJ found that communication aids are not provided, staff do not know how to use them, or the devices are inoperable.

   b. Persons with intellectual disabilities often are unable to communicate effectively and subsequently become frustrated. Their maladaptive behaviors convey this frustration and frequently get them an outcome that is better than no outcome at all.

   c. Without understanding the function and the precursors to maladaptive behaviors, any attempts to reduce or eliminate the behaviors are arbitrary and ineffective.

6. A major tenet of modern behavior programs is that they are based on a person's strengths. DADS focuses on a person's deficits, which departs from generally accepted practice.

III. Serving Persons in the Most Integrated Setting - Residents have the right to be treated in the most integrated setting appropriate to meet their individualized needs. As per the DOJ's recent letter, Texas continues to violate this federal requirement.

A. Only four percent (164 persons) moved from the state schools to community settings between September 2007 and September 2008. The DOJ found this low rate troubling because:

1. many residents of state schools are capable of living in the community, and

2. many of these residents—even those with more profound needs—can be accommodated in the community.

B. The state lacks a formal diversion process to ensure that community options are offered first.

C. DOJ also criticized the interdisciplinary teams (IDT) because they "operate as if they must either recommend or not recommend community placement."

D. IDTs also fail to educate families regarding available community options.

E. DOJ did mention the Community Living Option Information Process enacted by the 80th Legislature. However, the program only began in March of 2008, so the DOJ is not able to assess its impact at this time.

Texas has a much higher institutionalization rate than other states. The Texas Council for Developmental Disabilities (TCDD) recently reported that "[i]n 2006, Texas served 67 percent more individuals at its state schools/centers than the nationwide norm for utilization of such facilities." For that year, the national utilization rate was 12.8 individuals per 100,000 persons—the Texas rate was 21. Currently, Texas' rate is still about 20 individuals per 100,000 persons.

Although the DOJ began investigating the Texas' state school system in 2006, the state has failed to adequately address serious, systemic deficiencies. Consumers in state schools remain in imminent danger. While state legislators allocated an additional $48.8 million in general revenue funds to address staffing deficiencies in 2007, state leaders must develop a long-term reform plan to bring this broken system in line with national policies and best practices in the field of intellectual and developmental disabilities.

DADS' Interest Lists

For programs providing community services for the disabled, more than 82,000 wait on interest lists. In some programs, more Texans wait for services on interest lists than are actually being served. For example, in the Community Based Alternatives (CBA) waiver program, which provides home and community-based services as an alternative to nursing home services to those who are disabled or elderly, 21,050 get served while 29,316 wait for services.

37,187 wait for services from the Home and Community Services (HCS) program, which provides individualized services and supports to persons with mental retardation who are living with their family, in their own home, or in other community settings, such as small group homes.

21,496 wait for services from the Community Living Assistance and Support Services (CLASS) program, which provides home and community-based services to people with related conditions as a cost-effective alternative to placement in an intermediate care facility for persons with mental retardation or a related condition.

9,920 wait for services through the Medically Dependent Children's Program (MDCP), which provides services to support families caring for children who are medically dependent and to encourage de-institutionalization of children in nursing facilities.

Even if the Dept. of Aging and Disability Services (DADS) receives all of the funds requested for 2010-11, the state will not be able to serve the majority of individuals who need these services. The chart below highlights the number of people who will be served under the proposed budget and the number of people anticipated to be on the various interest lists in 2011.

	Average # of Individuals Served per Month	**Average # of Individuals on Interest List per Month**
HCS	20,636	61,710
CBA	29,576	43,389
CLASS	6,089	48,289
MDCP	3,029	29,123

State leaders must prioritize the needs of disabled and elderly Texans by creating a plan for phased reduction of interest lists by 2011.

Charge 2: Medicaid Outcome-Based Reimbursement

Medicaid Reform

In the 2007 Legislative Session Senate Bill (SB) 10 was passed with the hope that it will lead to comprehensive reform of the Medicaid program in Texas. The goal is to "optimize investment in health care to ensure more efficient use of available funding and best health outcomes for Texans."[i] This is expected to be achieved through the protection and optimization of Medicaid funding, reduction in the number of uninsured Texans, a focus on keeping Texans healthy, and the establishment of infrastructure to facilitate accomplishment of reform goals.[ii]

Even though a reform bill passed during the 80th Legislative Session, it is expected that more reform legislation will be passed in the future to achieve the goals of SB 10. However, SB 10 starts the process through several initiatives:

- The Texas Health Opportunity Pool Trust Fund will be established to provide premium subsidies to eligible Texans. It will also be available to offset uncompensated costs when providers use innovative measures to provide primary and preventative care.

- Implementing pilot programs such as positive incentives for healthy lifestyles, health savings accounts, and an incentive program to encourage routine health care visits in the hopes that they will increase consumer choice and responsibility as well as improve health outcomes.

- The Medicaid Health Insurance Premium Payment reimbursement program is intended to increase employment-based insurance options. In some cases, individuals will be able to opt out of Medicaid in favor of an employer-sponsored insurance program.

- Supporting the use and development of electronic health care information standards and records to increase efficiency and quality of patient care.

- If enrolled in college, former foster care children remain eligible for Medicaid until their 23rd birthday.

- Increasing the quality and efficiency while reducing the costs of providing care to children with special health care needs by using tailored benefits packages.

- Supporting the proper utilization of emergency services by implementing cost sharing for improper use of these services.

- Increase access to appropriate health care services by using outcome-based performance measures in health maintenance organization contracts.[iii]

How is the latest attempt at Medicaid reform really going to affect Texans' health? The full impact of this legislation has yet to be seen as most of the initiatives are not scheduled for implementation until 2009.[iv] In December of 2007, HHSC submitted a Medicaid 1115 waiver request to the U.S. Health and Human Services Center for Medicare and Medicaid Services for approval to secure federal funding. Many of the plan's details are still quite vague and many unanswered questions remain such as:

- How will the current social safety net be affected? In particular, public hospitals that currently serve as the safety net for their respective communities?
- Will the minimum standard for health benefits be adequate?
- Will all income levels be able to afford coverage including those whose income is below 100% of the FPL?
- Will it provide sufficient care to those with a higher level of need such as those with acute chronic conditions? The benefits plans proposed to date do not provide catastrophic coverage.
- Will access and availability be the same for all populations throughout the state?
- How will the lack of provider capacity be addressed?
- Will the scale of the program be large enough to meet the needs of most uninsured Texans?[v]
- Will the new plan infringe on enrollee's rights and protections?[vi]

Medicaid and CHIP Capitation Rate Disparities

Compounding the problem of the uninsured, the state spends significantly less per capita for Medicaid acute care services delivered on the Border than in other geographic regions of Texas. Payments to health care providers are inadequate, thereby perpetuating a provider shortage.[vii] As a consequence, there is a lack of general access to health care services.

The reason the state has historically spent less per capita for Medicaid on the Border than in the rest of the state is because rates are based on historic utilization of health care services in a county. The Border has low utilization due primarily to the lack of health care providers and infrastructure. It is common knowledge that El Paso ranks near the bottom in comparison to the rest of the state in terms of number of physicians, dentists, and every other type of provider. Infrastructure is so poor that the number of hospital beds per capita in itself is a crisis. For every 317 people in Texas, on average, there is one hospital bed; in El Paso County, there is one bed for every 339 people.[viii]

The Medicaid rates paid to physicians and dentists are woefully inadequate, particularly for a community like El Paso, where Medicaid is a major payer for health care services. This problem is not limited to just the traditional Medicaid fee-for-service program. Under the Medicaid managed care program, the capitation rates paid to participating Health Maintenance Organization (HMO) are set with the assumption that physicians will be paid the Medicaid fee-schedule. The chart *Adjusted Weighted Medicaid and CHIP Capitation Rate Disparities, 2006* shows the wide variation in rates in cities throughout the state.

Adjusted Weighted Medicaid and CHIP Capitation Rate Disparities, 2006

Organized by HMOs in Selected Care Service Areas

	Bexar Superior	Dallas Parkland	Harris Amerigroup	Lubbock Firstcare	Tarrant Amerigroup	Travis Amerigroup	El Paso Superior
TANF Children (> 1 year)	$81.18	$86.51	$75.28	$77.51	$74.73	$73.69	$83.04
TANF Adults	213.41	191.29	227.92	203.50	238.18	193.85	206.16
Pregnant Women	358.30	310.37	320.04	501.47	318.23	322.44	345.09
Newborns	563.36	622.35	678.97	340.97	465.19	520.87	495.48
Expansion Children (> 1 year)	80.14	101.25	77.68	87.19	69.77	85.50	89.97
Federal Mandate Children	67.63	73.67	70.18	72.44	78.20	61.79	70.24
CHIP (ages 15-18)	87.15	119.94	83.64	94.53	101.71	n/a	96.06

Source: Texas Health and Human Services Commission

Capitation rates, or the fee per child, paid to managed care organizations participating in Medicaid are based on historic expenditures per capita. Cities like El Paso, which have always had disproportionately low Medicaid expenditures per capita, find themselves in a difficult situation. To achieve higher capitation rates, they must spend more per capita. But because the capitation rates are so low, it is impossible to spend more per capita. The disproportionately low per-capita expenditures, the low managed care capitation rates, and the wholly inadequate Medicaid fee schedules have forced health care providers to significantly limit their participation in Medicaid or leave the program altogether. All of these factors negatively impact Medicaid recipients' access to services.

Charge 3: Resiliency and Disease Management (RDM)

Lack of treatment for mental illness is a growing problem across Texas. In terms of mental health spending per capita, Texas is 49 out of 51 (50 states plus the District of Columbia). In addition, Texas ranks 48th when it comes to the number of mental health professionals per capita. Texas does not have enough mental health care professionals or a continuum of care to address the needs of our residents—another consequence of inadequate funding. As a result, many will end up in jail or the emergency room, both of which are already close to capacity.

In 2003, the 78th Legislature changed the target priority population definition by limiting the number of adults that can receive ongoing services to those who have a diagnosis of schizophrenia, bipolar disorder or major depression. While the intent of RDM is to manage an underfunded service delivery system with better outcomes, the methodology is flawed. The targeted priority population should be based on a person's level of functioning and not based on diagnoses. Furthermore, Texans who do not have one of the three diagnoses cannot access ongoing services without a clinical override in the RDM system by the community mental health center, causing them to cycle in and out of crisis and often ending up in the criminal justice system or state hospital system.

At the October 13, 2008 hearing of the Senate Health and Human Services Committee, DSHS Commissioner David Lakey testified that:

- In FY 2008, 162,130 children were estimated to have a severe emotional disturbance, but only 29,621 children were served.
- In FY 2008, 453,075 adults were estimated to have a serious and persistent mental illness, but only 115,056 adults were served.
- Less than one in four who meet the criteria for the "targeted" priority population are provided ongoing services in the community.
- 87 percent of those who do not have services post-crisis are adults. This unserved population includes the following diagnoses: 14 percent with schizophrenia, 26 percent with bipolar disorder, 28 percent with major depression, and 32 percent with "other" mental illness.
    - In addition to serious mental illnesses, the adults who are not connected with care may be: homeless, in need of substance abuse treatment and primary health care, involved in the criminal justice system, and have experienced multiple psychiatric hospitalizations.
- Each year, approximately 876 children who already have a diagnosis of schizophrenia, bipolar or major depression do not receive ongoing care once the crisis is stabilized.

- Like adults, children in crisis may face significant issues in school, challenging behaviors in the home, substance abuse and involvement with the juvenile justice system.

Last year, the 39 Community Mental Health and Mental Retardation (MHMR) Centers across the state served almost 20 percent more individuals than they received funding for. These regional MHMR centers are grappling with the same issues—given the lack of adequate funding, do we compromise on quality or quantity? How many do we leave uncared for?

Without an infusion of additional monies, local taxpayers and a variety of other community entities—school districts to emergency room personnel to local police and sheriff departments—will be forced to deal with the consequences of a strained mental health system.

Charge 4: CPS Caseworkers and Caseloads

In testimony provided to the Senate Health and Human Services Committee on April 30, 2008, Madeline McClure, a respected expert who has devoted over ten years of her life to advocate for children's care issues, aptly stated, "[t]he safety, permanency and stability for children and families involved with CPS is contingent upon the quality, permanency and stability of the CPS workforce."

Caseworkers in Texas have the highest caseloads in the United States. In fact, our CPS conservatorship caseloads averaged 43.3 in FY 2007—about three times the 12-15 average caseload recommended by the Child Welfare League of America and almost twice the national average of 24.

To make matters worse, Texas pays its caseworkers one of the lowest salaries for child protective caseworkers in America—on average, under $31,000 per year. In 2005-06, Texas ranked 48th in the nation for a CPS caseworker's average salary. Notably, CPS caseworkers in New Mexico earn about $10,000 more a year than CPS caseworkers in Texas.

The quality of supervision of caseworkers in Texas is also abysmally low. With the high workload, low pay, and stressful working conditions, it is not surprising that the average turnover rate for CPS caseworkers in FY 2008 was 30.5%.

During the last legislative session, the Texas Senate considered an amendment to Senate Bill 758, which would have required 100% monthly caseloads (i.e., caseworkers would have been required to visit each of their children at least once a month). This amendment would have significantly reduced the caseworker to case ratio. And more importantly, the requirement would have increased the safety and well being of children in the custody of the state.

The amendment was voted down 20 to 11. The $18 million to pay for new caseworkers to reduce caseloads, increase monthly investigations, and ensure the safety of Texas children did not make the budget.

In April of this year, the Administration for Children and Families, which is a component of the U.S. Dept. of Health & Human Services, fined the state of Texas $4 million for not visiting their children often enough. A few months later, the same federal agency indicated that Texas would face additional fines for the same, unresolved issue based on the most recent review. Current federal policy requires that at least 95% of children in the care of the state are visited once a month.

Clearly, paying for care is a better alternative than paying for fines.

Charge 7: Wellness

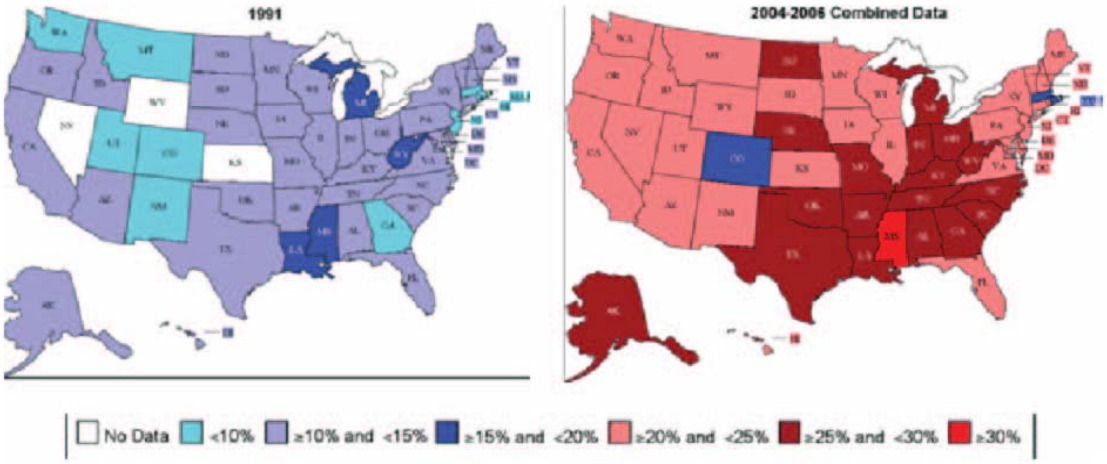
The Obesity Epidemic

The prevalence of obesity is developing into a nationwide health crisis. Since 1980 the rate of obesity in the United States has more than doubled, increasing from 15 percent to almost 33 percent.[ix] Obesity is one of the leading causes of preventable death in the United States.

The Centers for Disease Control and Prevention (CDC) estimates that as many as 112,000 Americans die each year due to an obesity-related cause.[x] The tragic loss of life due to obesity is accompanied by staggering costs to the health care system. CDC officials estimate the social costs of obesity amount to $78.5 billion each year.[xi]

The obesity problem is particularly serious in Texas, 64 percent of residents are either overweight or obese.[xii] As the chart *Number of Obese Texans Has Doubled Since 1991* shows, there was a 119.5 percent increase in the number of obese Texans from 1991 to 2006.

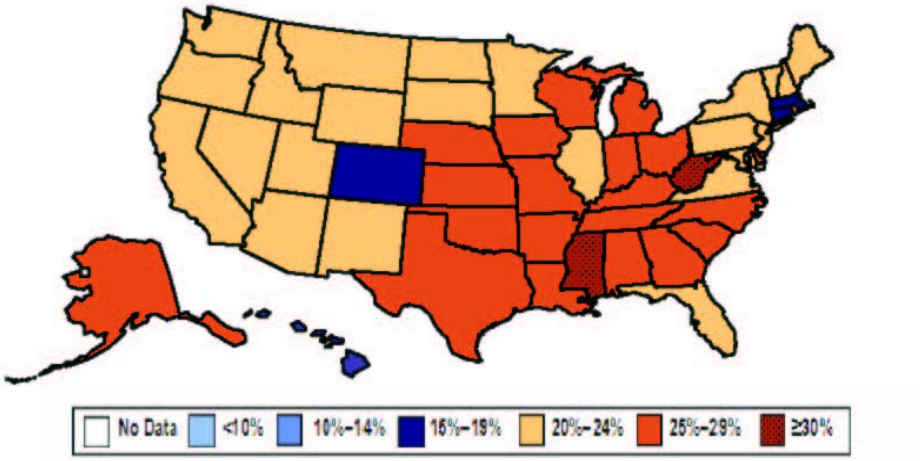
Number of Obese Texans Has Doubled Since 1991



Source: F as in Fat: How Obesity Policies are Failing in America (2007), Trust for America's Health (data from Behavioral Risk Factor Surveillance System, Centers for Disease Control & Prevention).

State health officials estimate that the direct and indirect costs of obesity in Texas are more than $3 billion annually.[xiii] The problem will continue to accelerate rapidly if not addressed, and costs to the state could potentially rise to $15.8 billion a year by 2025 if no action is taken.[xiv] The chart *Obesity Trends Among U.S. Adults* shows that Texas has one of the highest rates of obesity in the country.

***Obesity Trends* Among U.S. Adults*, BRFSS (2006)**
(*BMI ≥ 30 or ~ 30 lbs. overweight for 5' 4" person)



Generally, the Border has higher rates of obesity when compared to the rest of the state. The predominantly Mexican-American Border population is one of the most likely to suffer from obesity and obesity-related medical conditions, such as heart disease, in the United States. CDC data indicates that 73 percent of Mexican-Americans are overweight, compared to 62 percent of non-Hispanic Whites.[xv] Results from a survey coordinated by the Paso del Norte Health Foundation showed that the proportion of overweight individuals is higher in El Paso than it is for Texas as a whole. Also, more than half of El Paso's population between the age of 45 and 64 are overweight.[xvi]

What is Obesity?

According to health agencies obesity is a complex chronic disease caused by genetic, environmental, and behavioral factors. Health officials measure obesity using a formula called Body Mass Index (BMI) that compares weight and height. People with a BMI score over 30 are considered obese, and those with a BMI score between 25 and 30 are considered overweight.[xvii]

People with obesity are significantly more likely to suffer from conditions such as hypertension, osteoarthritis, dyslipidemia, type 2 diabetes, coronary heart disease, stroke, gallbladder disease, sleep apnea, breathing problems, and even some forms of cancer.[xviii] The chart *Increased Risk of Obesity-Related Diseases with Higher BMI* illustrates the serious consequences of obesity.

Increased Risk of Obesity-Related Diseases with Higher BMI				
Disease	**BMI of 25 or less**	**BMI between 25 and 30**	**BMI between 30 and 35**	**BMI of 35 or more**
Arthritis	1.00	1.56	1.87	2.39
Heart Disease	1.00	1.39	1.86	1.67
Diabetes (Type 2)	1.00	2.42	3.35	6.16
Gallstones	1.00	1.97	3.30	5.48
Hypertension	1.00	1.92	2.82	3.77
Stroke	1.00	1.53	1.59	1.75

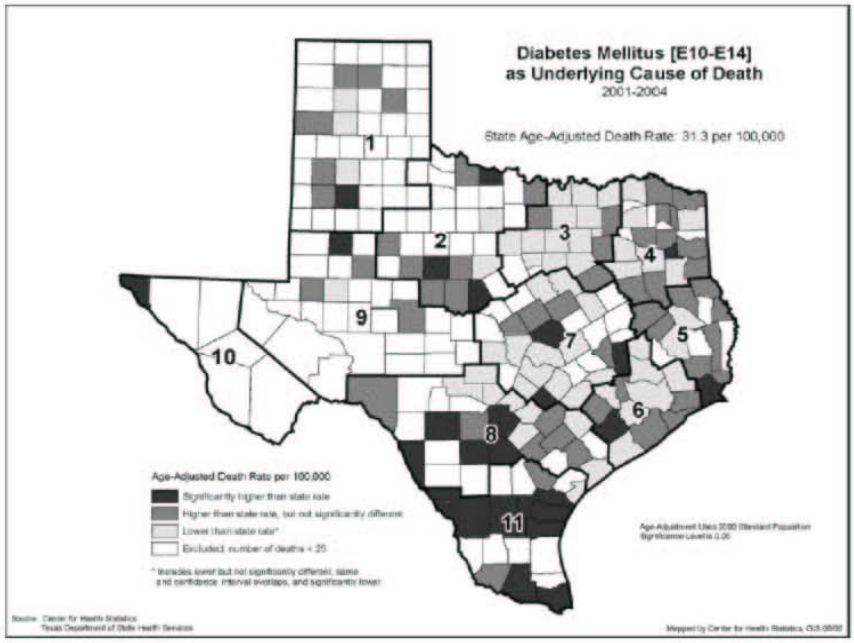
Source: Third National Health and Nutrition Examination Survey, Centers for Disease Control and Prevention. Analysis by The Lewin Group, 1999.

Obesity in our School Children

A particularly serious problem is the increase in obesity among children. Children with obesity are at greater risk of suffering from asthma, type 2 diabetes, cardiovascular disease, and sleep apnea.[xix] About 17 percent of U.S. children between 12 and 19 years old are overweight.[xx]In Texas, the number of students who are overweight is about 19 percent for children ages 10 to 17. Texas ranks sixth in a state-by-state comparison of childhood overweight rates.[xxi] According to the CDC, 64 percent of students in Texas do not participate in the recommended level of physical activity, which was defined as 60 minutes of physical activity at least 5 days a week. In addition, 40.5 percent of Texas students watch three or more hours of television every day.[xxii]

Obesity and Diabetes

Diabetes is a disease where the body does not produce or properly use insulin, a hormone used to convert sugar and other food materials into energy. In the U.S., 7 percent of the population will be diagnosed with this disease during their lifetime. [xxiii] According to the American Diabetes Association, diabetes is the fifth deadliest disease in the United States and contributed to over 224,000 deaths in 2002.[xxiv] People with diabetes are at higher risk for a stroke, heart disease, kidney disease, blindness, and nerve system damage.[xxv] The chart *Texas Diabetes Mellitus as Underlying Cause of Death, 2001-2004* shows that, generally, the Border has higher death rates due to diabetes than the rest of the state.



Increases in type 2 diabetes, where the body does not properly use insulin, may be one of the first noticeable consequences of the epidemic of obesity among young people. According to the World Health Organization, almost 90 percent of the diagnosed diabetes cases in the United States can be attributed to increases in weight.[xxvi] Approximately 15 million Americans suffer from diabetes and a staggering 54 million have pre-diabetes symptoms. Of those diagnosed, 176,500 are under 20 years old.[xxvii] Reports have indicated that type 2 diabetes is being diagnosed at higher rates among children and adolescents than previously, particularly among Hispanics/Latinos, American Indians, and African Americans.[xxviii] Type 2 diabetes rates are 1.7 times higher among Mexican-Americans than among non-Hispanic whites.[xxix] In addition, Mexican-Americans with diabetes are more prone to have retinopathy and end-stage renal disease than other ethnic or racial groups.

The incidence of diabetes is particularly high in the Border Region. The table *Texas Counties with the Highest Diabetes Prevalence Rates* lists all counties in the state with rates of 7.7 percent or above. All of these 16 counties are in the Texas-Mexico Border Region.[xxx] More than one million Border residents have been diagnosed with diabetes. Diabetes-related emergencies cost El Paso residents approximately $30 million in 2005.[xxxi]

Texas Counties with the Highest Diabetes Prevalence Rates, 2001

County	Number of Persons with Diabetes	Diabetes Prevalence Rate
Starr	2,763	8.0%
Webb	10,141	8.0%
Brooks	437	7.9%
Jim Hogg	289	7.9%
Maverick	2,422	7.9%
Zavala	615	7.9%
Duval	735	7.8%
Hidalgo	29,618	7.8%
Willacy	1,095	7.8%
Cameron	17,531	7.7%
Dimmit	538	7.7%
El Paso	36,151	7.7%
Frio	903	7.7%
La Salle	2,326	7.7%
Presidio	386	7.7%
Zapata	638	7.7%

Source: Texas Department of State Health Services

Economic Costs of Diabetes

In 2007, diabetes cost the United States $174 billion, $12.46 billion in Texas, and $515 million in El Paso alone.[xxxii] The annual costs of diabetes exceeds the amount spent repairing the damage caused by Hurricane Katrina ($150 billion). It is also more than has been spent on military conflicts in Afghanistan, Iraq, and the global war on terrorism combined.[xxxiii]

Much of the expenditures incurred by individuals with diabetes are indirectly related to the disease. Diabetes often leads to other costly medical complications such as cardiovascular and renal diseases. In addition, individuals with diabetes are likely to experience a loss of productivity through absenteeism, decreased job performance, deceased earnings and participation in the labor force due to permanent disability, and decreased productivity caused by premature mortality.[xxxiv]

Each person with diabetes spends an average of $11,744 a year on health care. One out of every five dollars spent on health care goes to treating someone diagnosed with diabetes. Last year, almost a quarter of the money spent on in-patient hospital care went to treat individuals with diabetes. These individuals have an increased rate of hospitalization. Once hospitalized, they stay an average of 50 percent longer than individuals in the same age range without diabetes. According to a spokesman from the American Association of Clinical Endocrinologists, the risk of death is twice as high for people with diabetes than for those of the same age without diabetes. In 2007, 284,000 deaths were attributed to the disease.[xxxv]

Current Diabetes and Obesity Initiatives

State agencies recognize the growing problems that obesity presents, and have developed some initiatives. In 2003, a statewide taskforce produced a plan for combating obesity in Texas. The plan calls for increasing general awareness of the problem of obesity and mobilizing schools, parents, and communities to address the issue. It also calls for encouraging policies that promote healthy eating and physical activity, and establishing procedures for data collection. An updated plan was later released with plans for 2005 through 2010 keeping the initial goals in mind.[xxxvi] In the 77th Legislative Session, the Texas Legislature established the *Texas Pediatric Diabetes Research Advisory Committee.* In late 2002, the advisory committee presented a plan that recommended the state should require physicians to begin reporting childhood diabetes diagnoses. The advisory committee also suggested that the state should establish a Texas Pediatric Diabetes Research Resource.[xxxvii]

The *Texas Diabetes Council,* established in 1983 and housed in the Department of State Health Services, produces a biennial state plan dedicated to reducing the prevalence of diabetes and increasing public and professional education regarding the disease. The latest plan, *Diabetes and Despair,* outlines the plan for 2008 and 2009.[xxxviii] The CDC has collaborated with other agencies to establish the *U.S.-Mexico Border Diabetes Prevention and Control Project,* which intends to use collaboration between all the Border states to reduce the prevalence of type 2 diabetes in the region. The project is has two phases. The first phase consists of a survey to determine the prevalence of the disease. Phase two includes a community intervention pilot project.[xxxix]

Other recent policies have attempted to improve nutrition and physical activity in schools. After state officials moved administration of the school lunch and school breakfast programs from the Texas Education Agency to the Texas Department of Agriculture (TDA) in 2003, the TDA issued a policy to improve nutrition in Texas public schools.[xl] The policy limits the availability of food of minimal nutritional value (FMNV) in public schools. FMNVs include food items such as carbonated beverages and most candies. Implementation of this policy began during the 2006-2007 school year and is scheduled to continue through the 2009-2010 school year.[xli] Sale of FMNVs are now restricted during the entire school day in elementary schools and half of the school day in middle and high schools.

Other current policy initiatives include reforming the policies regarding vending machines in schools and requiring elementary students to engage in thirty minutes of physical activity daily. Still, the state struggles with how to integrate nutritional meals into school lunches without losing valuable revenue from competing vending machines and fast food vendors. However, the country's top three soda companies agreed that, beginning in 2006 no more than 30 percent of beverages in vending machines located in high schools with sugary, carbonated soft drinks. By 2009, these types of beverages will not be available to students until after their last scheduled class.[xlii]

An initiative that has been successful on the Border is the Coordinated Approach to Child Health (CATCH) program, which integrates nutrition, fitness, and faculty and parental involvement in the prevention of obesity. The CATCH program increases awareness of nutrition

in the classroom, increases the amount of physical activity during physical education, serves healthier foods at lunch, and promotes health awareness among the students' families. A CATCH pilot program was introduced in several El Paso schools, and the CATCH program is currently being implemented in the Brownsville, Harlingen and McAllen school districts in the Rio Grande Valley region.[xliii] Starting in 2007, the state mandated that this type of program be integrated into all elementary schools.

Recent legislative efforts have expanded nutrition and physical activity initiatives. Starting with the 2007-2008 school year, all students in grades 3 through 12 will participate in a physical assessment. In addition, all middle school children (grades 6-8) will be required to participate in at least 30 minutes of daily physical activity.[xliv]

While steps such as these are important, there is no guarantee that current initiatives will dramatically slow the rise in obesity and related health problems. With the increasing prevalence of obesity in Texas and the Border region, it is important that citizens, policy makers, and health officials act quickly to address this issue. State leaders must act boldly to develop strategies aimed at the Border and Hispanics and work to build effective programs, a sound health care infrastructure, and adequate resources to fight the growth of obesity in the region.

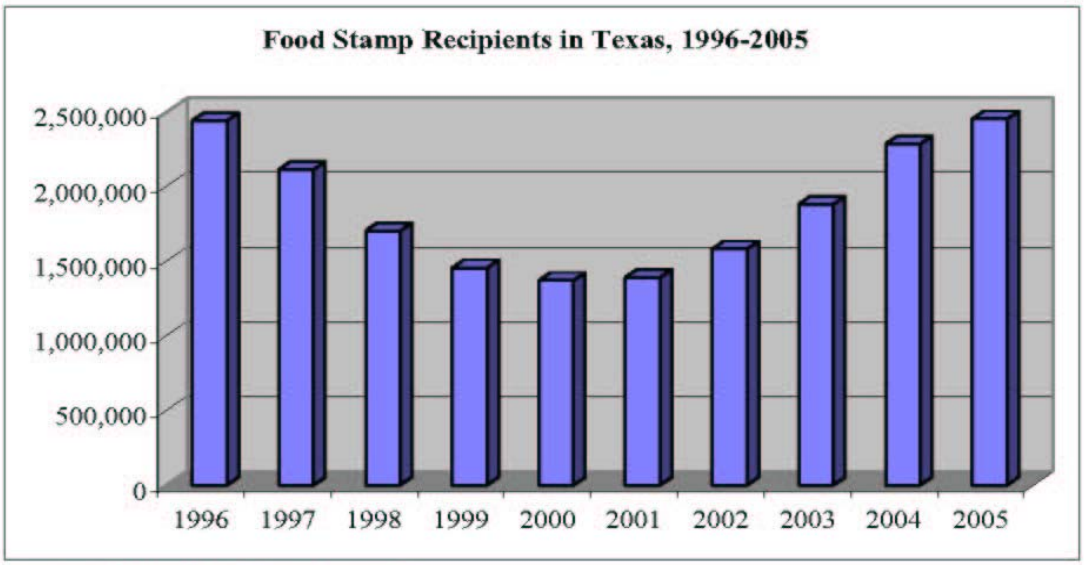
Hunger

Texas ranks first in the nation in the percentage of the population that is food insecure and fifth in the percentage that is food insecure with hunger.[xlv] Food insecurity is the lack of access to enough food to fully meet basic needs at all times due to a lack of financial resources.[xlvi] Despite the great need, public food resources are limited. The Texas Food Stamp Program (FSP) average benefit per person is only $93.40 per month.[xlvii]

Still, the FSP is one of the key weapons in fighting hunger in our state. It is one of the only programs whose enrollment is closely tied to the health of the economy. The FSP is run by the U.S. Department of Agriculture and administered statewide by the Texas Health and Human Services Commission. Annually, about 2.3 million Texans receive food stamps and, in December 2007, El Paso had 139,936 residents participating in the program.[xlviii]

Problems with the Food Stamp Program

After 1996, the FSP experienced a decline in enrollment as well as a decrease in benefits. Welfare reform in 1996 changed the way food stamps were administered. This legislation has affected Texans more significantly than people in other states. Since 1996, each state averaged a loss of $30 million in benefits. Texas, losing $129 million, is the state with the largest reduction in funding.[xlix] Despite the changes in program policy, there has been an enrollment increase in recent years due to the lagging economy and an increase in the number of Texans who are below the poverty level, as shown in the chart, *Food Stamp Recipients in Texas, 1996-2005.*



Source: Texas Health and Human Services Commission

Not all of those eligible for the FSP are receiving benefits. Nationally, only 61 percent of eligible households participate in the program. Participation rates are even smaller among Hispanics with only about 50 percent of eligible individuals receiving benefits. That means that

almost 4 million Hispanics who could be receiving assistance are not.[l] As a result, Texas has lost out on $4.5 billion from the federal grant program.[li]

There are several reasons for low participation. First, the eligibility rules are confusing. Because the rules have changed several times over the past ten years, with the same people floating in and out of eligibility, many people who are eligible do not realize that they are. The rules regarding legal immigrants with citizen children can also be confusing and result in many people not receiving their benefits. Community outreach programs are currently putting a great deal of effort in education so that all eligible persons are aware of the program and their access to it.

One of the major changes greatly affecting the Border community is the loss of benefits by legal immigrants. In 1996, the policy changed and legal immigrants were no longer eligible until they had been U.S. residents for five years. Because of this decision an estimated 300,000 people who would have been eligible under previous eligibility standards are now ineligible.[lii] Cuts like these damage the local economy since $1.84 of state economic activity is generated for every food stamp dollar spent.[liii] In El Paso alone, legal immigrants lost 21.5 percent of their purchasing power due to cuts in FSP.[liv]

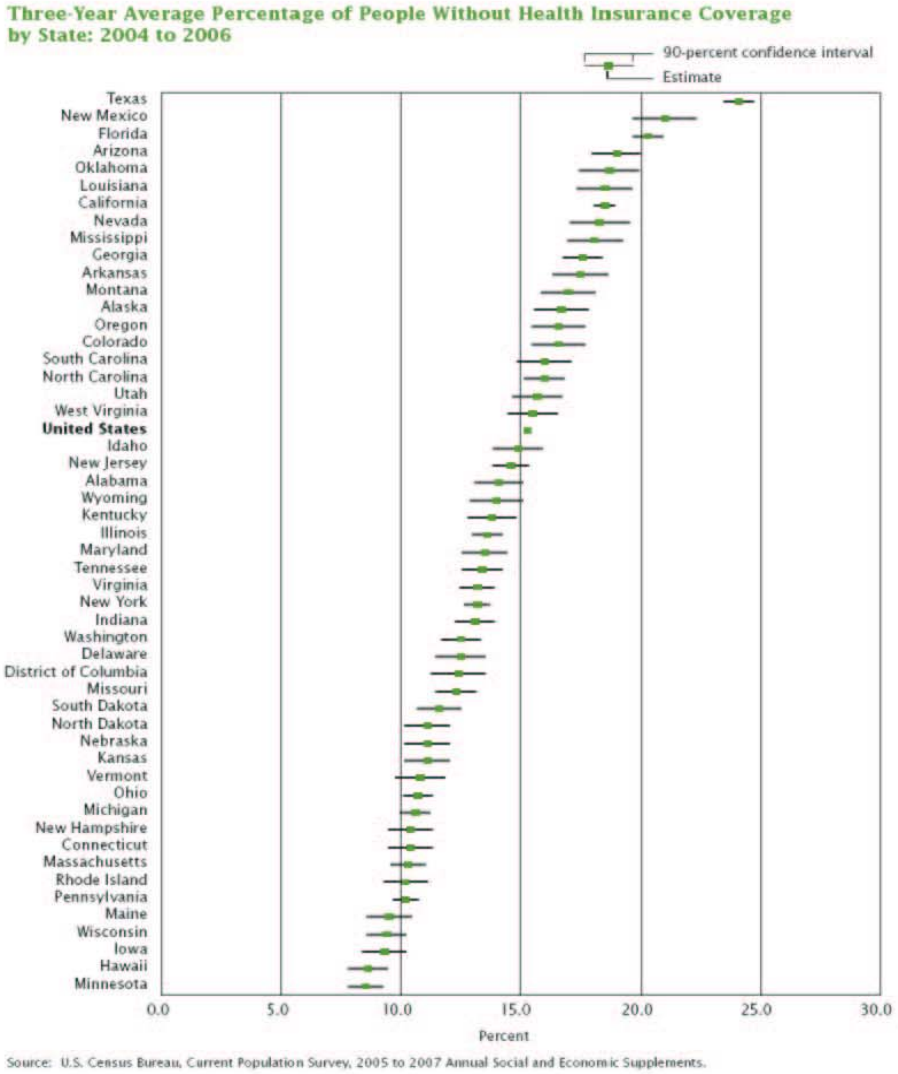
The FSP also has low participation due to the stigma associated with receiving government assistance.[lv] The use of fingerprinting adds to this stigma.[lvi] This practice was put in place to cut down food stamp fraud. While there has been no evidence that fingerprinting deters fraud, the practice has been a deterrent for people to apply, thus decreasing the number of participants.

Participation is not the only problem facing the FSP. Cuts in benefits have decreased the program's effectiveness. On average, food stamp benefits last 2.3 weeks out of every month.[lvii] Benefits average out to only $1 per meal, which does not come close to feeding a person for an entire month.[lviii] Issues like these, as well as accessibility, should be considered in restructuring the FSP. The state should not make it difficult for those who need assistance to receive it.

Joint Charge 2: Health Care Workforce

We cannot adequately understand the current shortage of health care professionals without first laying out the background on the uninsured in this state. Where health care professionals choose to practice is inextricably linked to what percentage of a region's population has health insurance.

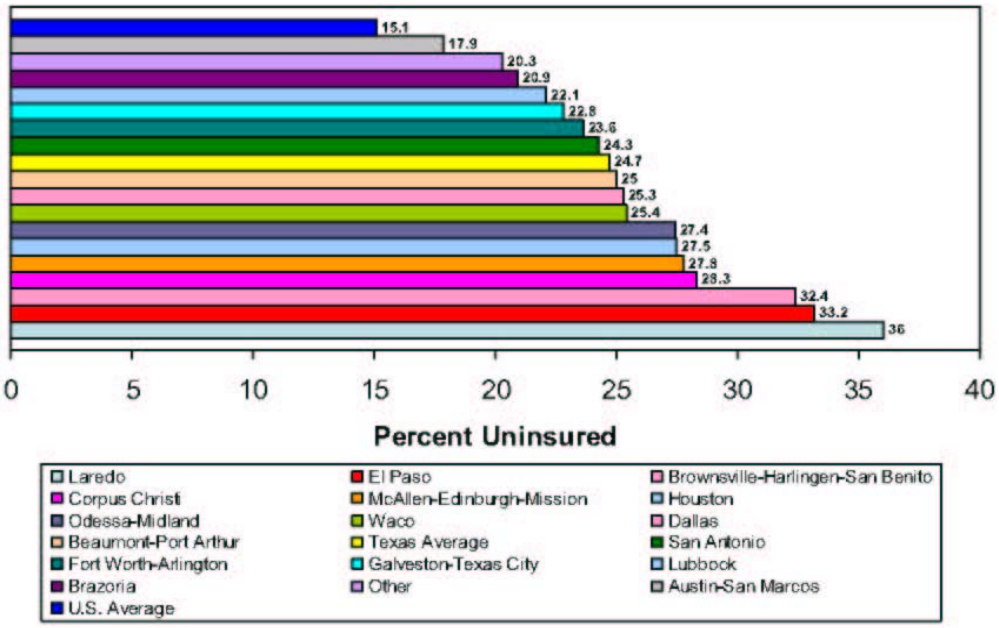
Texas has more uninsured residents than any other state, averaging 24.1 percent between 2004 and 2006.[lix] During the same time period, however, only 15.3 percent of the entire United States was uninsured.[lx] Indeed, as the chart *Three-Year Average Percentage of People Without Health Insurance Coverage by State: 2004 to 2006* shows, Texas had the highest percentage of uninsured residents.



Source: U.S. Census Bureau, Current Population Survey, 2005 to 2007 Annual Social and Economic Supplements.

In 2006, one out of every four Texans was uninsured.[lxi] No Texas city—not Dallas, Houston or even Austin—reaches the national average for people with health insurance. As the chart below shows, the most uninsured Texas cities are all in the Border region with rates of 36% in Laredo, 33.2% in El Paso, 32.4% in Brownsville/Harlingen/San Benito, 28.3% in Corpus Christi, and 27.8% in McAllen/Edinburgh/Mission.

No Texas City Reaches the National Average of Citizens with Health Insurance



Source: The Uninsured, Texas State Comptroller's Office, April 2005.

Many factors contribute to this alarming statistic, perhaps the most important of which is the fact that in large areas of Texas, the jobs available to low-wage workers do not offer full family health insurance coverage.[lxii-lxiii] Another contributing factor is that for those who are employed, union membership is low. Back in 1993, right-to-work labor laws were enacted to favor owners over workers. So unlike workers in California and many states in the Midwest and East, Texas workers do not have union protections on health contracts and have limited ability to organize and demand such coverage.

Unlike most of the developed world, the majority of U.S. citizens depend on job-related health insurance.[lxiv] Employment problems, then, translate directly into health insurance

problems. Low wage jobs in the restaurant, hotel, janitorial, and other service industries often do not offer health insurance. Even when employers offer coverage, the premiums an employee must pay to cover themselves and their family make insurance an unrealistic luxury. The Hispanic population is overrepresented among those who cook our food, clean our offices and homes, and care for our children. In providing these services, they buoy the high standard of living for middle class Americans, but they themselves often receive minimum pay and no benefits.[lxv]

Although Americans pay more for health care, we do not receive better or more health services.[lxvi] Recent studies have shown that Americans pay more for health care primarily because of higher charges for health care services including hospital stays, doctor's visits and pharmaceuticals.[lxvii] Another reason that U.S. health care costs have increased at a staggering rate is the proportion of health care dollars spent on administrative costs. In 2005, the U.S. spent $98 billion on administrative costs. Of the $84 billion associated with private payers, 64% was attributable to administrative costs of underwriting risks, sales and marketing. Notably, this number does not include the administrative costs associated with denial management. Public programs, however, do not incur these administrative costs. In fact, administrative costs only account for 3-5% of the Medicaid budget and 3% of the Medicare budget.[lxviii]

Although the Texas Border is one of the poorest areas in the nation, Border hospitals charge some of the highest rates for services. Of the top 100 most expensive hospitals in the U.S., three operate in the Border region. In fiscal year 2003-2004, Brownsville Medical Center (Brownsville, TX) was #8 on the list, Sierra Medical Center (El Paso, TX) was #37, and Providence Memorial Hospital (El Paso, TX) was #46. These hospitals' total charges as a percent of total costs were 813.57%, 698%, and 675%. The national average total charge to cost ratio for the 4,292 hospitals studied is 205.84%.[lxix]

Texas families face both financial and non-financial barriers to obtaining health insurance. Due to the rising costs of health care, the number of employers who offer health care coverage is dwindling. There are several additional factors that limit access to private or employer-sponsored insurance, including high costs, pre-existing conditions, lack of job tenure, a part-time schedule, and employment in jobs that do not offer health insurance or only do so at a prohibitive cost to the employee.[lxx] Fewer Texans receive insurance through their employer than in other parts of the nation. Nationally, about 60 percent of citizens have insurance through employers. In Texas, 52.2 percent of residents have employer-sponsored insurance coverage. In 2006, only four states (Arkansas, Louisiana, Mississippi, and New Mexico) had lower rates than Texas.[lxxi] Even when Texans are offered employer-sponsored health insurance, the average premium an employee must pay to cover their family is higher than the national average.[lxxii] Premiums are even higher for workers employed by small businesses. The average premium was $4,608 for an employee in a firm with fewer than 10 employees in 2005, and $4,065 for firms with more than 50 employees, a difference of $543 per year per employee.[lxxiii]

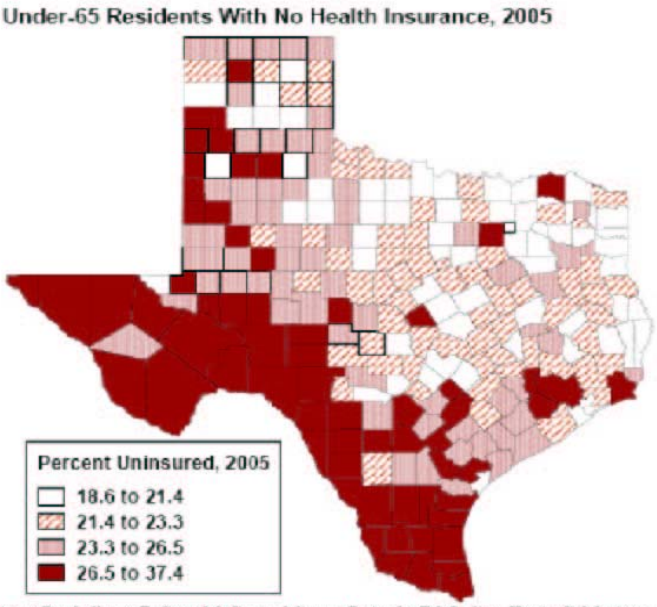
In addition to high premiums and high hospital charges for services, providers in the Border region receive lower reimbursement rates for services. All of these factors place extraordinary stress on the economic foundation of health care, thereby creating a vicious cycle. When payments to providers are reduced, providers start raising their gross charges. In response,

insurance companies raise their premiums, and inevitably, the health care costs of providing insurance increase. This, in turn, allows fewer and fewer individuals to be able to afford health care coverage.

Another contributing factor is that Texas' large Hispanic population has one of the lowest rates of insurance coverage in the country.[lxxiv] For this population, a lack of proficiency in English, lack of familiarity with insurance principles, a fear of governmental bureaucracies and low educational levels add to general labor market and social service difficulties.[lxxv] This unique combination of factors means that the uninsured population of Texas faces multiple barriers to coverage that present state lawmakers, employers, and policy makers with major challenges in addressing their insurance needs.

Other barriers include factors that limit access to public insurance, such as complicated application and renewal procedures, assets tests, inadequate outreach efforts by agencies charged with administering health-related programs, and coverage for only the poorest of the poor. For example, in 2007, a working parent of two had to make less than $3,696 per year or 22.3 percent of the federal poverty level (FPL) to qualify for Medicaid in Texas.[lxxvi]

The chart *Under-65 Residents with No Health Insurance, 2005* shows where the uninsured live in the state.



Source: Eva DeLuna Castro, Anne Dunkelberg, F. Scott McCown, Miryam Bujanda, Ed Codina, Kevin C. Moriarty, *The Texas Health Care Primer, Revised 2007*, Center for Public Policy Priorities, November 2007.

In Texas, 35 of the state's 254 counties account for 80 percent of the state's uninsured.[lxxvii] The table *Texas Counties with the Ten Largest Uninsured Populations* shows that half of the ten counties with the highest number of uninsured are on the Border while the other half comprise the urban centers of the state.

Texas Counties with the Ten Largest Uninsured Populations

County Name	Uninsured Population	% of Statewide Total
Harris	812,628	17.2
Dallas	499,970	10.6
***Bexar**	349,043	7.4
Tarrant	325,556	6.9
***El Paso**	231,534	4.9
***Hidalgo**	173,769	3.7
Travis	147,461	3.1
***Cameron**	103,474	2.2
Denton	81,413	1.7
***Nueces**	79,930	1.7
All Other	1,907,434	40.5

*Counties in the Border Region

Source: Task Force on Access to Health Care in Texas, Code Red: The Critical Condition of Health in Texas, 2006, Online: http://www.coderedtexas.org/files/Report_Chapter02.pdf

Why is it so important that Texas make health coverage a top priority? The lack of health insurance coverage places adequate medical care out of reach for many poor families in Texas. In 2004, one in five Texans admitted that in the past year they needed to see a doctor but did not because of the high cost.[lxxviii] Individuals close to the poverty threshold, who are for the most part the working poor, are at particularly high risk of lacking coverage. In Texas, 35 percent of people with an annual income between $10,000 and $15,000 are uninsured—a much higher rate than any other income range in the state.[lxxix] Almost half the children in Texas are covered by employment-based insurance through a family member. Another quarter are covered through public programs such as Medicaid and the Children's Health Insurance Program (CHIP). The remaining quarter of the population of Texas children are uninsured.[lxxx]

These children living without coverage are less likely to receive needed medical care including; preventative care, vaccinations, dental screenings, and access to mental health services.[lxxxi] Uninsured children are at risk for missed diagnoses of serious illnesses and hospitalizations for preventable conditions.[lxxxii] They are more likely to be hospitalized due to asthma and ear infections. These conditions, if left untreated, can lead to serious health problems and even death.[lxxxiii] Although some inequalities in access to medical care between the rich and poor have decreased due to Medicaid and CHIP, poor children are still far less likely to receive dental care than children in more affluent families. Only half of children living below the FPL visited a dentist in the past year compared to almost three-fourths of children above the FPL.[lxxxiv] Uninsured children are also less likely to be treated for conditions such as asthma and ear infections that can lead to more serious health problems.[lxxxv]

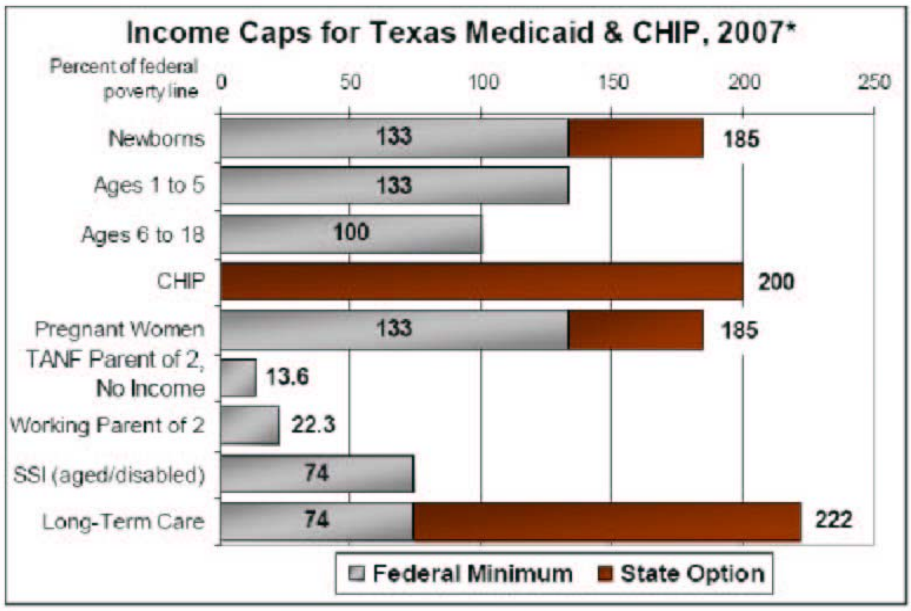
Because they are less likely to have a regular source of care, uninsured individuals are more likely to use the emergency rooms, community and migrant health centers, and other publicly-funded health facilities as their primary source of health care. One in every five uninsured individuals uses the emergency room regularly, compared to 3 percent of insured individuals.[lxxxvi] Often, these publicly-funded facilities, especially in Border counties, are funded on the nation's lowest per capita property tax base, severely limiting their ability to care for these

children. As a result, routine care received in emergency rooms is excessively expensive and may be of lower quality than that received from a personal physician familiar with a child's overall health.[lxxxvi] The lack of a stable, consistent source of care places uninsured individuals at a high risk of being diagnosed in later stages of disease, which leads to a higher mortality rate than that of insured individuals.[lxxxvii]

Demographic Profile of the Uninsured* - *Age

Among the total population of Texans, adults 18-24 years old were less likely to have health insurance than other age groups; only 59.2 percent of adults in this age bracket had health insurance for all or part of 2006.[lxxxix] Because of Medicare, almost all Texas residents over 65 had health insurance—97 percent had coverage of some kind.[xc] Over 20 percent of Texas children do not have any health insurance. Children from birth to 5 years are slightly less likely to have coverage than children who are between 6 and 17 years old.[xci]

More children are living without health insurance in Texas than have in previous years. In fact, there are 62,000 more uninsured children living in the state today than there were in 2002.[xcii] Over the same time period, the number of children living below the FPL increased from 1,318,889 to 1,435,607.[xciii] The poorest Texas families can qualify for government insurance programs such as Medicaid and CHIP. However, a gap exists between the income cap for program eligibility and minimum income necessary to obtain private insurance.[xciv] The chart *Income Caps for Texas Medicaid & CHIP, 2007* details the maximum amount of money a family of three can make and still be eligible for Medicaid and CHIP. For reference, in 2007, the FPL for a family of three was set at $17,170.



*Annual income limit is for a family of three for child and parent categories. For SSI and Long-Term Care, income cap is for one person.[xcv]

Race

Underrepresented minorities are more likely to live without health insurance than other groups. Within the United States, Hispanic people have much higher rates of being uninsured than non-Hispanics. 34.1 percent of Hispanics are uninsured while 12.6 percent of non-Hispanics are uninsured. The difference between these groups is larger when just looking at Texans. Almost 40 percent of Hispanic Texans do not have health insurance. For non-Hispanics, the rate was only slightly higher than the national average with 15.9 percent of non-Hispanic Texans living without insurance in 2006.[xcvi] Hispanic adults, especially immigrants, are over-represented in the service sector. They are usually not offered employer-sponsored health insurance or the costs of premiums required for individual or family coverage place such coverage out of reach. The chart *Uninsured Texas Population by Race/Ethnicity* shows that Hispanics are disproportionately uninsured compared to other minorities.

Uninsured Texas Population by Race/Ethnicity (2006)

Race/ Ethnicity	Number Insured	Number Uninsured	Percent Uninsured within Race/ Ethnicity Category	Percent of Total Uninsured
Anglo/Other	10,302,329	1,690,183	15.3	31
African American	1,986,365	622,560	23.9	11
Hispanic	5,194,378	3,172,434	37.9	58
Total	17,483,072	5,485,177	23.9	100

Source: Texas: Distribution of Non-elderly Uninsured by Race/Ethnicity (2006), The Henry J. Kaiser Family Foundation, available at: www.statehealthfacts.org.

Hispanic workers are less likely to get health benefits through their job, even though their employment rates are similar to those of whites. Hispanics are much more likely to have jobs in companies that do not offer employment-based coverage.[xcvii] Often these are small companies with fewer than 25 employees, including retail stores, restaurants, and construction firms. Because of the rising costs of health care, small companies are unable to compete in the market when they offer health insurance to their employees. Gaps in health coverage or a complete lack of health insurance can have devastating health consequences.

Hispanics are less likely than other racial or ethnic groups to have a regular doctor, regardless of whether they have insurance. Without a regular doctor, an individual is less likely to have preventative care such as blood pressure and cholesterol screenings. Those without a regular doctor are less confident in their ability to manage chronic conditions.[xcviii] One report found that Hispanics utilize ten different preventative services less than other ethnic groups. These services included colorectal cancer screening, assistance from a health professional to quit smoking, and being vaccinated against pneumococcal disease.[xcix]

This problem becomes everyone's concern when doctors and hospitals pass the cost of uncompensated care of the uninsured to paying patients and local taxpayers, which has the effect of increasing the cost of health insurance. Employment-based health insurance premiums could

be 15 percent lower if there were no uncompensated costs for uninsured Texans' health care.[c] In 2005, $10.2 billion was spent on uncompensated care in Texas. Due to the high cost of providing uncompensated care, the normal health care premium is $805 more than the national average[ci]

Contrary to popular belief, Hispanics are less likely than other ethnic groups to get health insurance through a welfare program. Only 15 percent of Hispanics were insured through a public program compared to 21 percent of white citizens and 32 percent of African Americans.[cii] Salvador Gomez, the Board Chairman of the Colorado Hispanic Chamber of Commerce explained these data by suggesting, "[i]t's a pride thing. These are people who will get in the back of a truck and drive thousands of miles just to get a job. They aren't looking for a handout. They're looking for a job."[ciii]

Income Level

A direct relationship exists between income level and health insurance coverage. Individuals with income levels below 200 percent of the FPL, or an annual income of $34,340 for a family of three, are almost three times more likely to be uninsured than individuals making more than 200 percent of the FPL.[civ] Further, 31.6 percent of Americans below the FPL ($17,170 per year for a family of three) were uninsured during some part of 2006, compared with 6.7 percent of those at 400 percent of the FPL ($68,680 per year for a family of three).[cv]

Employment

Being insured is linked to employment status. Nationally, for every 100 people who become unemployed, 85 people, including family members, lose their health insurance coverage.[cvi] But having a job, even a well-paying one, does not guarantee health insurance coverage. In fact, nationally, 20 percent of individuals working full-time with incomes from 200 to 400 percent of the FPL ($34,340 to $68,680 per year for a family of three) were still uninsured.[cvii] In Texas, 74 percent of the uninsured either worked full- or part-time during 2006 or were not of working age (under 15 years old).[cviii] Many jobs simply do not offer health insurance or only offer it at a level where the employee's contribution proves too expensive.

The Texas economy relies heavily on small businesses; 73 percent of all businesses in the state have fewer than 50 employees. However, only 37 percent of these small businesses offer health insurance. In contrast, nationally, about 61 percent of employees working for small businesses were at companies that offered health insurance in 2003—almost twice the state rate.[cix] In addition, only 65 percent of employees working in small businesses offering coverage enrolled in the employer-sponsored program.[cx]

Finally, one of the major reasons for the large number of uninsured children is the fact that many children in low income families are not enrolled in public programs for which they are eligible. The Congressional Budget Office has stated that between 5 and 6 million children in the country who are eligible for either Medicaid or SCHIP (the federal version of Texas' CHIP) are not enrolled.[cxi] There are several factors that contribute to the high number of eligible, but unenrolled children. One of the major barriers preventing enrollment in public programs is a

lack of accurate information about Medicaid and SCHIP. Another factor is a long and complicated application process. Studies have indicated that children in Hispanic families must deal with additional barriers when enrolling in public insurance programs.[cxii] This combined with the large Hispanic population in Texas could be a reason for the high rates of uninsured children in the state.

Texas' dubious distinction of leading the nation in uninsured children and adults results from a number of barriers to coverage that presents the state with serious challenges. Further, the large number of uninsured Texans along the Border presents the state with unique problems. This population is concentrated in some of the poorest counties in the state in which restricted labor markets and high rates of unemployment further compound demographic and labor supply problems. Increasing the insurability of the population through employment would be the most appealing solution; however, it is clear that reducing the number of uninsured and vulnerable Texans will require new and imaginative initiatives.

Other States' Universal Health Care Initiatives

To solve the problem of Texas' high rates of uninsured, state leaders often have to look to other states. As of January 2008, eight states had enacted or announced universal health care plans. Once fully implemented, programs in Vermont, Massachusetts and Maine aim to cover all residents, while plans in Hawaii, Illinois, Pennsylvania, Washington, and Wisconsin will provide coverage to all children.[cxiii] Fourteen other states and the District of Columbia have passed legislation that would increase the availability of coverage for children.[cxiv]

In July 2006, Illinois implemented the All Kids program, the first children's universal coverage program in the country. Using state funds exclusively, all uninsured children in the state are eligible for coverage without regard to income, health status, or citizenship. Between July 2006 and April 2007, 50,000 previously uninsured children were enrolled in the All Kids program.[cxv]

By passing the Dirigo Health Reform Act in 2003, Maine hoped to make health coverage affordable to every citizen by 2009. Two initiatives were included in the plan. Beginning in January 2005, the DirigoChoice program offers subsidized insurance for small businesses, self-employed workers, and individuals. The second initiative expanded the state's Medicaid program to include more low-income parents.[cxvi] By September 2006, 11,100 individuals and 700 small businesses were enrolled in the DirigoChoice program and 5,000 additional low-income parents had insurance through Medicaid.[cxvii]

Adding to the Health Care Crisis: The Budget Cuts of the 78th Legislature

Despite the health crisis and significant health disparities on the Border, and the fact that Texas already trails other states in the allocation of health care resources, lawmakers still made inhumane health and human service budget cuts during the 78th Legislature. Texas shortchanged its citizens with accounting gimmicks that actually added up to huge reductions in services and benefits for our populace. These budget cuts were cleverly disguised to make it appear as if

funding for health and human services is being "maximized," but sadly, quite the opposite has occurred. Funding for such state-supported health programs as Medicaid and CHIP, nursing home and hospice care, community care, university teaching hospitals, state and local district employee insurance coverage, and health care coverage for adult and youth inmates, has been reduced by:

- reducing income guidelines and eliminating participation;
- making it more difficult for people to become eligible (or remain eligible) for services;
- eliminating benefits that were previously available; and
- reducing payments to health care providers who are serving those who are eligible.[cxviii]

Based strictly on the dollar amount being appropriated to them, some health care programs actually received an increase from their 2002-2003 funding levels. However, this is highly misleading, because while some of these programs may show a slight increase in their overall general revenue funding, this increase does not keep up with rapidly increasing health care costs, which are rising at a rate of more than 10 percent annually.[cxix]

House Bill (HB) 2292 was passed during the 78th Legislative Session to cut twelve health and human service agencies down to five, and to centralize powers under the Health and Human Services Commission (HHSC). HHSC now coordinates administrative functions across the system, provides eligibility determination for health and human services programs and administers Medicaid and CHIP. Additionally, it oversees the four other health and human services departments:

- **The Department of Family and Protective Services** includes the programs previously administered by the Department of Protective and Regulatory Services. DFPS began services February 1, 2004.

- **The Department of Assistive and Rehabilitative Services** combines the programs of the Texas Rehabilitation Commission, Commission for the Blind, Commission for the Deaf and Hard of Hearing and the Interagency Council on Early Childhood Intervention. DARS began services on March 1, 2004.

- **The Department of Aging and Disability Services** consolidates mental retardation and state school programs of the Department of Mental Health and Mental Retardation, community care and nursing home services programs of the Department of Human Services, and aging services programs of the Texas Department of Aging. DADS began services on September 1, 2004.

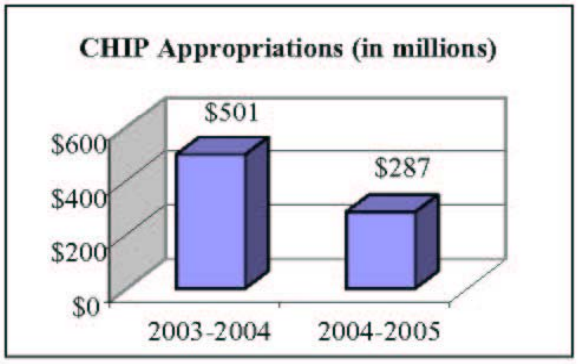
- **The Department of State Health Services** includes the programs provided by the Texas Department of Health, the Texas Commission on Alcohol and Drug Abuse, and the Health Care Information Council, plus mental health community services and

state hospital programs operated by the Department of Mental Health and Mental Retardation. DSHS began services on September 1, 2004.

Under the previous system, most people applied for public benefits at one of 381 local eligibility offices administered and staffed by the Texas Department of Human Services (DHS). HB 2292, however, mandated the use of call centers to determine eligibility for the major health and human services programs, including Medicaid, CHIP, the Food Stamp program, and Temporary Assistance for Needy Families (TANF). The resulting debacle that has occurred since HHSC has attempted to privatize this responsibility and transfer it to a contractor will be discussed shortly.

Cuts to CHIP

As the chart *CHIP Appropriations (in millions)* shows, the legislative budget cuts reduced CHIP appropriations by 43 percent. The program's budget was $501 million during 2003-2004 and only $287 million in 2004-2005. Program changes also led to stricter eligibility policies, fewer benefits, higher co-pays and premiums, and a 90-day waiting period.[cxx] These inhumane cuts were made when Texas was already ranked 50th in the percentage of children who have health insurance.[cxxi]



Cuts to Medicaid

Medicaid also took a severe hit during the 78th Legislative Session. Funding for the 2004-2005 biennium rose a meager 3.8 percent, and new eligibility standards and enrollment procedures had far-reaching ramifications that left many citizens out in the proverbial cold, with no benefits.[cxxii] In 2003, approximately 2.5 million Texans, including 1.6 million children, received Medicaid acute care services on a monthly basis. As a result of these cuts, enrollment was expected to shrink by 4,000 in 2005.[cxxiii] However, if the eligibility policies been left untouched, 350,000 additional Texas children and adults could have potentially been covered by Medicaid.[cxxiv]

These cuts also severely affected low-income pregnant women. Medicaid can be used for prenatal care, delivery, and postpartum care for 60 days after delivery. Due to the budget reductions almost 13,000 women were no longer eligible for services. This translates to a loss of

approximately $110 million in reimbursement for health care providers in Texas over a two-year budget cycle, and fewer women that could access quality prenatal care.[cxxv]

Furthermore, Texas lost $41.2 million in state and federal funds from the 2004 mental health budget, and Medicaid coverage for adults who need counselors and psychologists was wiped out completely. Approximately 200,000 adults had to make do without these services, resulting in health crises at the local level, for families and in emergency rooms.[cxxvi]

Cuts in Texas' Temporary Assistance for Needy Families

Other worthy programs were also reduced through stricter eligibility requirements. TANF is a program that provides cash assistance on a monthly basis for poor Texas families with children under the age of 18. After the 78th Legislative Session, a family of three (mother and two children) could qualify for TANF if their gross income was below $784 a month and their assets were valued at less than $1,000. On September 1, 2003, more than 19,000 adults and 41,000 children in Texas lost all their TANF benefits because of a new full-family sanction policy. This also caused most adults receiving TANF to lose their Medicaid benefits. The state predicted that 75 percent of those who lost assistance were children.[cxxvii]

The new legislation that was enacted wiped out coverage for such basic necessities as eyeglasses and hearing aids for adults on Medicaid.[cxxviii] It also eliminated coverage for elderly, disabled and adult TANF recipients seeking help in such high-demand areas as social work, marriage and family therapy, podiatric and chiropractic care, psychological counseling, and licensed professional counselors.[cxxix] Further, the state chose not to maximize its federal matching dollars requested by the HHSC, leaving approximately $1.6 billion in federal Medicaid and CHIP funding "on the table"—$1.6 billion that could have gone toward providing health care to Texans.[cxxx]

These budget cuts and reductions cost the state and local jurisdictions millions of dollars in unnecessary emergency care that could have been prevented. Balancing the budget on the backs of kids and people who need these programs the most contradicts the government's mission. Medicaid and CHIP are social insurance programs designed to protect our most vulnerable citizens. By continuing to chip away at these services, we are forcing more and more Texans to fend for themselves and exposing them to a greater risk of chronic or debilitating illness or even premature death. In addition, costs passed onto local taxpayers will increase taxes. That is not the recipe for a healthy populace or economy. Steps to redress these problems must be taken immediately, so Texas leaders can begin to repair the damage that was created through these draconian budget cuts.

Partial Restoration of the Budget Cuts in the 79th Legislature

The 79th Regular Session restored some of the cuts from the disastrous 78th Regular Session, but many of the major cuts remain in disrepair. Despite the increased funding, Texans who rely on public health programs such as CHIP and Medicaid will still suffer the effects of an under funded system.

Some CHIP Cuts Restored

Fortunately, the state budget restored vision care, dental care, and mental health coverage to 2003 levels, thus undoing the cuts from the 78th Legislature. Dental services were delayed numerous times before they were finally included in CHIP beginning in April 2006.

However, many of the cuts from the previous session remained. In fact, none of the bills filed that would have restored CHIP coverage back to 2003 levels ever received a public hearing. Thus, any changes that were made to the CHIP program were instituted through the budget bill.[cxxxi] The changes made during the 78th Legislative Session that remained include:

- children are only covered for a six month period, not a full year;
- upon initial enrollment, children are not covered for 90 days;
- elimination of the income deductions that allowed families to deduct child care or child support payments from the income level that determines eligibility;
- an asset limit added for families who are above 150 percent of the FPL;
- a 2.5 percent cut in the reimbursement rate for CHIP medical providers; and
- a reduction in outreach and marketing funds.[cxxxii]

Those intent on reducing the number of children who can benefit from CHIP coverage also employed a different tactic. The budget assumes a lower CHIP caseload and cost-per-client than what HHSC had initially projected. As a result of these assumptions, the general revenue allocation was reduced by $60.0 million for CHIP.[cxxxiii]

Some Medicaid Cuts Restored

In addition to CHIP, some of the cuts made in the 78th Legislature to the Medicaid budget were repaired. The budget restored coverage for eyeglasses, hearing aids, mental health professional services, and chiropractic and podiatry care for all 863,000 adult Medicaid clients, 78 percent of whom were aged or disabled.[cxxxiv] Total Medicaid funding was increased by $1.8 billion over the 2006-2007 biennium with the addition of programs such as the Medicaid buy-in program for workers with disabilities and enhanced family violence funding.

Similar to CHIP, though, the budget assumed a lower Medicaid caseload growth and cost-per-client than what HHSC had originally projected, thus lowering the Medicaid budget by $929.7 million in general revenue.[cxxxv] Further, Medicaid provider rates were not increased back to the 2003 levels.[cxxxvi]

Policy Changes During the 80th Legislature

During the 2007 Legislative Session changes were made to both Medicaid and CHIP programs. If properly implemented, some of the modifications will lead to an increase in service delivery and a simplified enrollment process. However, there is still work to be done to insure that all of Texas' children in low-income families can consistently access quality health care.

Further Restoration of CHIP

A $1 billion increase in funding was approved by the 80th Legislature, thereby bringing the total amount of funding available for CHIP to $2 billion. Some of the additional funding will be allocated to prenatal services, which will allow more women and newborns to be covered under CHIP.[cxxxvii] This legislation further restores some of the cuts made during the 78th Legislative Session.

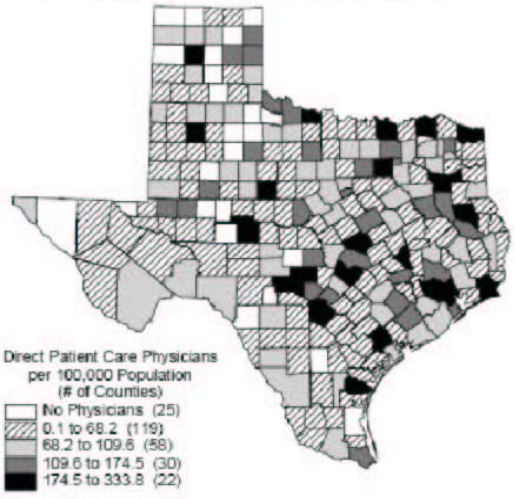
Several other changes made to CHIP regulations are expected to increase enrollment by almost 130,000 children. HB 109 eliminated several barriers put in place by the 78th Legislature. This piece of legislation eliminated the 90-day waiting period, restored CHIP enrollment from six months to one year, allows parents to deduct child care expenses when calculating income, and increases the limit for the assets test.[cxxxviii] Again, these policy modifications return CHIP guidelines to their pre-78th Legislative Session status. However, one important change is that HB 109 places the assets test into statute whereas the act of the 78th Legislature allowed HHSC to use an assets test to determine eligibility, but did not require it.

Shortage of Health Care Professionals

There is a strong need for physicians in Texas across the state—119 counties are designated as Health Professional Shortage Areas (HPSAs). Another 68 counties have an HPSA designation for part of the county or for a special population in the county. Only 67 counties do not have the HPSA designation.[cxxxix]

The chart, *Direct Care Physicians per 100,000 in Texas, 2007,* highlights the fact that physicians are not evenly distributed among the regions of Texas. Metropolitan Border areas had an average of 145.2 physicians per 100,000 residents, non-metropolitan Border areas averaged even less, with only 70.7 per 100,000. Non-border areas have a much higher ratio of physicians with 170.7 per 100,000 in metropolitan areas and 88.7 per 100,000 in non-metropolitan areas.[cxl]

Direct Care Physicians per 100,000, 2007

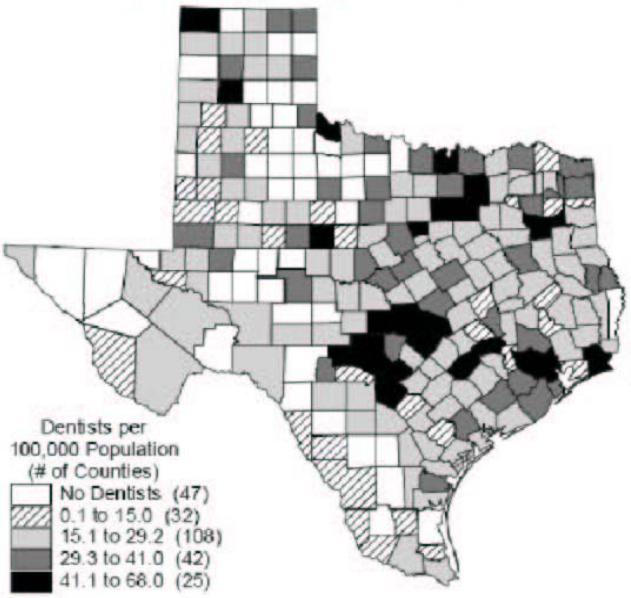


Source: Texas Medical Board
Produced by Health Professions Resource Center, Center for Health Statistics, Texas Department of State Health Services

The Texas population has grown from 14.7 million in 1981 to over 23.9 million in 2007.[cxli] By 2030, the population of Texas will grow to more than 33 million.[cxlii] With the population continuing to increase, Texas will need to graduate more medical school students in the future. In 2000, 44 percent of physicians in Texas graduated from a Texas medical school, with 35 percent coming from other states, and 21 percent coming from other countries.[cxliii]

The chart *Dentists per 100,000 Population, Texas, 2007* shows where dentists are located throughout the state. The Border has an extreme shortage of dentists, falling far short of the state average of 36.5 dentists per 100,000 population. In Border metropolitan areas, there are 15.7 dentists per 100,000 population while non-Border metropolitan areas have 41.1 dentists per 100,000. Even worse, Border non-metropolitan areas have only 11.8 dentists per 100,000 population while non-Border non-metropolitan areas have 25.2 dentists per 100,000.[cxliv]

Dentists per 100,000 Population, 2007



Source: Texas Department of State Health Services

29 of the 43 counties in the Border region are currently designated "Dental Health Professional Shortage Areas" (26 whole counties; 3 partial counties).[cxlv] Furthermore, 12 counties in the Border region have no dentists, and 15 counties have no dental hygienists.[cxlvi]

The shortage of health professionals extends to many other disciplines. The Border counties are also considered medically underserved areas because of the lack of pharmacists, nurses, physician's assistants, and dental hygienists.[cxlvii]

SELECT BORDER FOCUS:

Oral Health Care

Oral health is a key component of overall health. As former U.S. Surgeon General David Satcher observed in *Oral Health in America*, "the mouth is a mirror," which reflects an individual's overall health.[cxlviii] Studies have shown a link between oral health and other diseases such as ear and sinus infections, weakened immune systems, diabetes, heart and lung diseases as well as arteriosclerosis, heart attack, stroke, and birth defects.[cxlix] Periodontal organisms can enter the bloodstream and cause inflammation in certain organs, including the liver, major blood vessels, and the placenta.[cl]

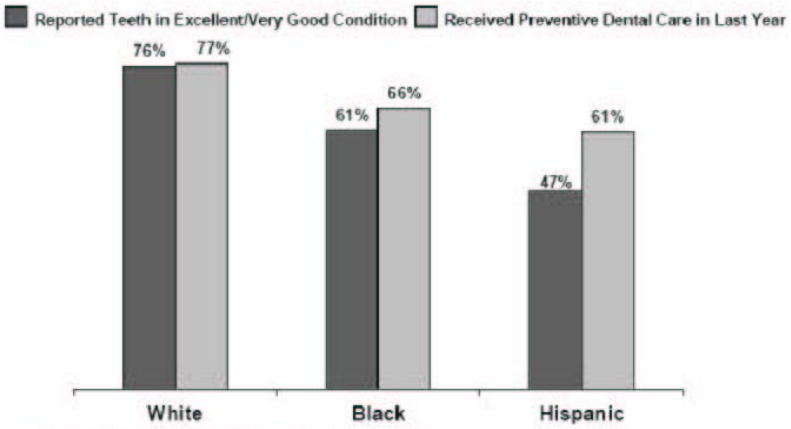
Along with serious illness, oral diseases can cause debilitation, significant pain, interference with speech and eating, along with poor self-image, nutrition, social development,

and quality of life, over use of emergency rooms, valuable time lost from school, and in the worst cases even death. Tooth decay is the most prevalent chronic disease among children in the U.S.[cli] It is estimated that children with oral disease miss over 51 million hours of school each year.[clii] The Texas Department of State Health Services (TDSHS) reports that dental caries (cavities) are the leading cause of school absenteeism in Texas.[cliii] Even when they are in class, children with untreated dental problems have trouble concentrating on their schoolwork, thereby hampering their ability to learn.

The Texas-Mexico Border region reflects many national health trends that threaten to overwhelm the current health care delivery system, including dental care. The combination of disproportionately large segments of the population in the lower socioeconomic strata, lower overall education levels, and ethnic groups with genetic predispositions to chronic diseases make the Border region even more susceptible to oral disease. Multiple challenges to Border health care require innovative solutions.

Two segments of the population, the young and elderly, are particularly vulnerable to disease. Pre-school Hispanic children experience higher dental carie rates than any other race or ethnic group.[cliv] Hispanic children of all ages are less likely to get dental care than their non-Latino counterparts. The chart *Disparities in Dental Disease and Care for Minority Children* illustrates the high rate of dental decay among Hispanic children.

Disparities in Dental Disease and Care for Minority Children



Source: Kaiser Family Foundation Commission on Medicaid and the Uninsured

Expenditures for dental services alone made up 7.5 percent of the nation's health expenditures in 2003—$67 billion.[clv] This is a significant increase from 1998 when expenditures on dental services were $53.8 billion or 4.7 percent of total health expenditures.[clvi] In 2003, 30.6 percent of the 22 million Texans spent money on dental services at an average cost of $523 a person.[clvii]

Sources of Dental Care

Oral health care consists of education, preventive care, and restorative care. Ideally, all Texans should receive regular preventive care (an annual exam and twice-yearly "prophylaxis" or cleanings) and restorative care (fillings, crowns, dental prosthetics, etc.), as needed.[clviii]

Like other Texans, most residents of the Border region receive care from dentists in private practice. Although some individuals have coverage from private or employment-based dental insurance, many obtain care on a fee-for-service basis, paying the cost out of pocket. Children in Texas from low-income families are eligible for two state programs that provide dental care coverage: Medicaid and CHIP. Except for certain residents of long-term care facilities or individuals with disabilities, Texas does not provide health or dental coverage for adults.

To the extent that they obtain care at all, adults who are unable to pay for dental care—or children who are not enrolled or do not qualify for Medicaid or CHIP—obtain care in hospital emergency rooms; from non-profit, charitable, or public health dental clinics; or from individual dentists who donate their services. A brief description of major sources of dental care in the Border region follows.

Medicaid Dental Program

Medicaid, the state's largest health care program, provides dental care through the Texas Health Steps Program. In addition to individuals with disabilities and certain residents of long-term care facilities, Medicaid covers children under age 1 to 6 in families with annual incomes up to 133 percent of FPL and children age 6 to 18 in families with annual incomes up to 100 percent of FPL.[clix] The dental program covers a wide array of services and usually pays for as much care as an eligible patient requires.[clx] Dentists must enroll in the Medicaid program in order to receive reimbursement. Reimbursement is based on a statewide fee schedule, and most fees are less than dentists' overhead costs.

CHIP Dental Program

The Children's Health Insurance program, established in 1997, is intended to provide coverage for children in working families that earn too much to qualify for Medicaid, but not enough to afford private insurance. Since the program=s inception, CHIP dental benefits have been capped. Currently, preventative care is capped at $175 for a 12-month period.[clxi] Therapeutic services are capped based on a three-tier program. The higher the tier level, the higher the maximum allowable amount for therapeutic services. The child's tier level depends on factors including timely renewal, the amount of time a child has been enrolled in CHIP, and recent gaps in coverage. Tier levels for therapeutic services are:

- **Tier I:** Pays up to $175 of preventative services and up to $200 of therapeutic services.

- **Tier II:** Pays up to $175 of preventative services and up to $300 of therapeutic services.

- **Tier III:** Pays up to $175 of preventative services and up to $400 of therapeutic services. [clxii]

The caps limit the therapeutic dental care (fillings, caps, root canals and extractions) and preventive dental care (annual oral evaluation, x-rays, prophylaxis and sealants) that children enrolled in CHIP can access.[clxiii]

The Texas Department of State Health Services—Division of Oral Health

The Oral Health Group of the Texas Department of State Health Services (TDSHS) plays a key role in efforts to improve the oral health of residents of the Border region, which includes parts of four TDSHS regions. The Group provides a variety of services from its headquarters in Austin and through regional offices in Uvalde (Region 8), El Paso (Region 9/10), and Harlingen (Region 11).[clxiv]

In addition to helping oversee dental services provided through Medicaid and CHIP, the group helps individual communities around the state optimize the fluoride content of public water supplies by providing financial and technical assistance with the installation and management of their fluoridation systems. Studies have established that fluoridation of public water supplies is the most cost effective means of combating dental disease for people of all ages.[clxv]

School-based Clinics

Some school districts in the Border region employ full or part-time nurses to provide a range of health care services, which can include visual screenings for oral health problems. According to TDSHS, school-based oral health clinics facilitate collection of data about the oral health of school-aged children. School-based clinics also serve as sites for the TDSHS Sealant Program, which furnishes sealants for children to prevent the development of dental decay on the chewing surfaces, where 80 percent of all cavities occur.[clxvi] In TDSHS Region 8, approximately 1,200 eligible children receive preventive dental sealants each year.[clxvii]

Charitable Care

Local dental societies and other organizations operate a variety of ongoing and one-day programs to provide dental care to indigent residents of the Border region. In El Paso, the El Paso District Dental Society has been active in initiating several programs for the city's indigent population. These include the El Paso Coalition for the Homeless, where over 35 El Paso dentists volunteer to provide comprehensive dental care for needy patients.[clxviii]

Dentists Who Care, a charitable program organized in 1996 by the Rio Grande Valley Dental Society, operates a mobile dental van to provide dental examinations. The program provides access to dental care for hundreds of children who fall in the gap between Medicaid and

private insurance in South Texas. By 2004, the program had served over 12,200 children and provided $1.3 million in charitable care.[clxix] Each November, reservists from the Texas National Guard and other military units provide free care to indigent residents of remote communities on both sides of the Texas-Mexico border between Del Rio and Presidio. Individual dentists in private practice also provide substantial amounts of care for disadvantaged individuals at no charge or at reduced fees.[clxx]

Access to Dental Care Issues

Like Medicaid programs in most other states, the Texas Medicaid program has a hard time attracting and retaining dentists, resulting in a shortage of providers in some communities. Longstanding problems include low reimbursement rates, with fees often below a dentist's overhead costs, as well as administrative issues, including the burden of dealing with complicated rules and regulations, delays in processing claims or reimbursements, unwarranted or redundant requests for additional documentation, and lost dentist or staff time. Despite these problems, dentists in many communities in the Border region are more likely to participate in the Medicaid program than their counterparts in other parts of the state because of the large number of low-income residents along the Border. While this fact is encouraging, additional Medicaid dentists are still needed in virtually all parts of the Border region.

Legislators and state health and human service officials are well aware of the barriers to greater dentist participation in the Medicaid program and have been working with Medicaid, the Texas Dental Association, and other dental organizations to address those barriers. Remedial efforts to date include simplification of the dental provider enrollment application (reducing it from almost 50 pages to less than 5), increases in reimbursements for dental services, and periodic meetings between state health and human service officials, the Medicaid office, and participating dentists.[clxxi]

The Role of Dental Hygienists and Access to Care

Dental hygienists are uniquely positioned to help close the gap in dental coverage by providing low cost preventive care and educating this population about the need for prevention. Several innovative projects have already been initiated with great success in the Lower Rio Grande Valley by the dental hygiene program at Texas State Technical College (TSTC) in Harlingen and the Texas Department of Health (TDH). Over the past five years, dental hygiene volunteers, dentists, and students have been providing free dental exams, radiographs, prophylaxes, fluoride, and pit and fissure sealants through the Sealants Across Texas program and the dental hygiene clinic at Texas State Technical College. Over 800 children have received free preventive dental care and have been referred to dentists for restorative dental treatment.[clxxii]

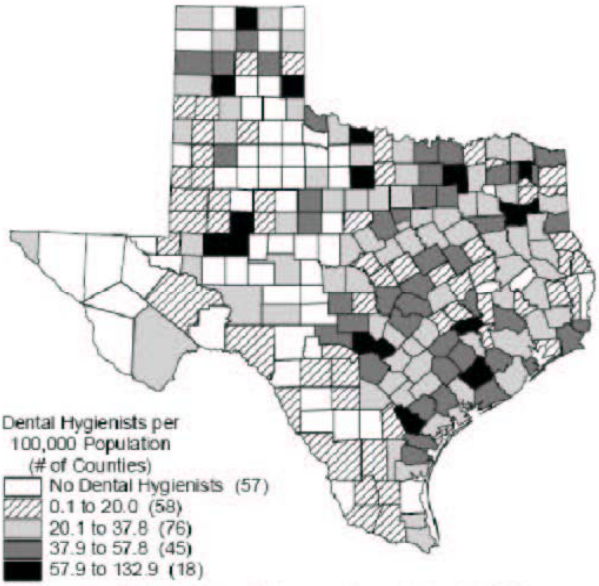
Access to Dental Hygiene Services

Dental hygiene educators have worked hard to meet the growing oral health needs of Texas citizens, and those of the Border region in particular. Twenty one dental hygiene programs exist in the state, and all continue to take the maximum number of students their capacity allows.[clxxiii] There are three dental hygiene programs located in the Border Region.[clxxiv]

Two dental hygiene programs in the Border region, El Paso Community College and TSTC in Harlingen have graduated dental hygienists at their maximum capacity. From 1992 to 2000, the number of graduates of Texas dental hygiene programs has risen from 250 to 380. In comparison, Texas dental graduates have dropped from 248 in 1992 to 230 in 2000.[clxxv]

The chart *Dental Hygienists per 100,000 Population, Texas, 2007* exhibits the ratio of dental hygienists per 100,000 population. The table illustrates that most of the Borderland counties have lower than average numbers of dental hygienists when compared to the state average of 38.7 providers per 100,000 population. For 2007, the number of dental hygienists per 100,000 were 18.6 for metropolitan Border areas, 8.4 for non-metropolitan Border areas, 42.8 for non-border metropolitan areas, and 30.5 for non-metropolitan non-border areas.[clxxvi]

Dental Hygienists per 100,000 Population, 2007



Source: Texas Department of State Health Services Health Professionals Resource Center, December 2007

It is surprising that given these statistics, recent graduates of many of the dental hygiene programs are unable to find full-time employment. Regulations that require dental supervision, when a documented shortage of dentists exists, limit the ability of dental hygienists to treat those who need it most. The medical community has been very pro-active in utilizing registered nurses to provide low-cost care to a large number of patients. However, many believe that registered dental hygienists are currently underutilized in addressing the disparities in oral health care in the Border region, and could play a much more active role in improving Border health if regulations were reviewed and potentially lifted.

Mental Health Issues and Inadequate Resources

In the Texas Borderlands, there is a great strain on families and communities due to the inability of the public mental health care system to serve those at risk. Exacerbating the gap between need and availability of mental health care are the growing societal pressures stemming from economic downturn, unemployment, and threats to homeland security.

Thanks to advances in medical research, many serious mental illnesses can now be treated with enormous success. Many biological mental disorders and illnesses respond to proper treatment, and new medications are being released that are immensely effective. However, Texas has not had the capacity to provide mental health care and medications to all those who need them. Due to budget constraints, there has been insufficient funding for the state agency charged with helping low-income Texans with mental illness, the Texas Department of State Health Services (TDSHS). For example, during the 78th Legislative Session, the public mental health system experienced enormous funding cuts, and policy changes were implemented that have made it even more difficult to access mental health services. However, the 80th Legislature restored some funding by allocating $82 million to increase the availability of crisis mental health services.[clxxvii]

Poor Access to Mental Health Care

Studies released by the Mental Health Association in Texas have indicated that there is a gap between the need and the availability of services. There are many at risk individuals that are eligible for services but cannot receive them due to a lack of resources.[clxxviii]

This problem is even greater in the Borderlands. For example, El Paso is currently experiencing a crisis in mental health care. Before September 2005, the budget allocation from TDSHS to El Paso Mental Health and Mental Retardation (EPMHMR) and the El Paso Psychiatric Center provided for 64 beds. However, TDSHS reduced the budget allocation by eight beds. Since that date, the EPMHMR crisis assessment facility and the Psychiatric Center often turn away and refuse to assess mental health patients due to this lack of funding. EPMHMR is the mental health authority responsible for immediately screening and assessing El Pasoans in a mental health crisis. If necessary, they are then referred to and admitted into the Psychiatric Center. This system, however, is broken.[clxxix] El Pasoans who need emergency psychiatric services are instead being forced upon area hospitals, who are ill-equipped to provide inpatient psychiatric treatment. Further, these patients are being forced to wait in the emergency room for many hours until a bed can be found for them at the Psychiatric Center.[clxxx]

This crisis became so severe that the El Paso County Attorney filed a lawsuit against TDSHS stemming from the repeated failure by EPMHMR and the Psychiatric Center to adequately treat El Paso's mentally ill.[clxxxi] The lawsuit is currently pending in El Paso District Court.[clxxxii]

The entire Borderlands region experiences this lack of mental health care. The table *Estimated at Risk, Eligible, and Served by the TDMHMR in 2002* shows the numbers of people served for certain border counties. A higher percentage of adults who are at risk and eligible are

served than children, 35 percent for adults and 20 percent for children. These statistics are even more shocking when compared to non-border counties who serve 38 percent of their eligible and at risk adults and 26 percent of their children.

Estimated At Risk, Eligible, and Served by TDMHMR in 2002

	Adults			Children		
	Estimated Adults At Risk and Eligible for MHMR Services	Adults served	Percent of Adults Who Were Served	Estimated Total Children At Risk and Eligible for MHMR Services	Children served	Percent of Children Who Were Served
Brewster	180	144	80%	49	27	55%
Cameron	5,979	2,199	37%	2,965	417	14%
Culberson	55	27	49%	23	*	*
Dimmit	180	76	42%	85	20	24%
El Paso	12,343	5,705	46%	5,577	1,322	24%
Hidalgo	10,033	1,993	20%	5,331	613	11%
Hudspeth	59	14	24%	28	*	*
Jeff Davis	44	21	47%	12	6	48%
Kinney	65	10	15%	21	*	*
Maverick	797	315	40%	451	129	29%
Presidio	130	86	66%	61	11	18%
Starr	902	212	24%	526	201	38%
Terrell	21	*	*	7	*	*
Val Verde	804	259	32%	373	96	26%
Webb	3,371	1,250	37%	1,861	535	29%
Zapata	216	96	44%	103	69	67%
BORDERLANDS	35,182	12,407	35%	17,473	3,446	20%
TEXAS	**397,166**	**150,241**	**38%**	**151,464**	**39,591**	**26%**

Source: Texas Department of Mental Health and Mental Retardation

Estimated at risk and eligible for services was defined using the proportions in the 2003 Strategic Plan for TDMHMR

Lack of adequate coverage for mental health treatment leads to desperate choices. Without proper intervention, children's mental health issues often lead to far worse problems later in life, including involvement in the criminal justice system, which costs the state significantly more in the long-run. For example, in Texas, $682 million is spent annually on individuals that rotate through jail, hospitals, and detoxification centers. Only $92 million is used for treatment in community mental health centers.[clxxxiii]

Prisons: De Facto Mental Health Care

Over time, a nationwide trend has developed in which mentally ill individuals are sent to prison, contributing to the rising prison population. Only 5 percent of the U.S. population has a mental illness, compared to 16 percent of the prison population.[clxxxiv] In addition, the resources available in the community are not adequate, often leading to incarceration. Inmates with a mental illness are more than twice as likely to have been homeless prior to incarceration. Almost half of all children in the Texas Youth Commission or the Juvenile Probation Commission have a mental illness.[clxxxv]

Once mentally ill prisoners are booked, how do they receive treatment? Screening mechanisms are often inadequate, due to the significant differences across prison systems.[clxxxvi] Therefore, we do not have accurate numbers on the mental health population in Texas prisons. As of February 2004, 17 percent of Texas inmates were reported to have mental health problems. Typically, prisons have a clinic staffed with a medical nurse and a psychiatrist, but inmates do not get adequate treatment and there is not sufficient follow-up.[clxxxvii]

A needs assessment indicated the demand for an intensive mental health facility in a Travis County prison, which opened in December 2001. These inmates incur higher costs, but "the special unit reduces the need to outsource, the number of suicides, and bridges gaps within the community," according to the Travis County Sheriff's Department.[clxxxviii] In 2004, the federal government authorized $50 million to provide grants to fund programs that facilitated collaborations between mental health service providers, the juvenile justice system, the criminal justice system, and substance abuse treatment providers "to improve access to effective treatment for people with mental illnesses involved with the justice system."[clxxxix] In 2006, 27 grants were awarded through this program and, in 2007, 26 grants were awarded.[cxc]

Unique Challenges of the Borderland

The Mental Health Association in Texas visited a number of towns along the Texas Border to learn more about the unique challenges of the region. Through community forums, residents and service providers outlined the following challenges for those seeking mental health care and those providing that care.[cxci]

- The U.S. border with Mexico is somewhat artificial. People can cross back and forth and move about freely within ten miles of either side of the border.
- The number of people living in poverty along the border is very high.

- There is a prevalence of people with substance abuse and co-morbid mental health issues.
- Housing for people with mental illness and substance abuse problems on the border is a particular challenge.
- Since drug costs are so high, and prescription drugs are cheaper in Mexico, many people go across the border to have prescriptions filled even though this is against Texas state law.
- Transportation is a significant challenge; there are insufficient resources to hospitalize people with a mental health crisis and transportation to the closest facility is a huge problem.
- Border residents need more integrated services and funding streams.
- The stigma of mental illness in the Borderlands is hard to overcome and there is a great need for more community support.

Recommendations From Forum Participants

- An anti-stigma campaign to provide the public with accurate information about mental illness and the treatments available.
- Increased collaboration between schools, universities, and stakeholders.
- Implement a Family to Family Education Program with Mexico. This is a peer mentoring program that pairs families with a newly diagnosed member with families who have experience living with mental illness.
- Education of younger generations.
- More Patient Assistance Programs, which provide financial assistance for education.
- Review the research and educational materials produced in Mexico to see if Texas can learn from them.
- Make mental health a key priority of the United States - Mexico Border Health Commission.[cxcii]

Mental Health and Traumatic Brain Injury Services for Returning Veterans

According to an in-depth study released by the RAND Corporation last April, because of extensive time in combat for today's soldiers returning from Iraq or Afghanistan, almost one in five soldiers have symptoms of post-traumatic stress disorder (PTSD) and/or major depression—nearly four times the rate for soldiers before deployment as well as the rate for the general population. Of great concern is that only half of these soldiers have sought treatment. Further, the costs of medical treatment and associated loss of productivity are estimated at more than $6 billion in just the two years following deployment.

More than one in ten active duty service members are stationed in Texas. Furthermore, Texas has deployed more National Guard and Reserve members to the wars in Afghanistan and Iraq than any other state. These members are more likely to be affected by mental health issues than active duty members. In addition, spouses and children are subsequently affected. For example, in communities with a concentrated number of those who have been deployed to Iraq or Afghanistan, studies show higher rates of child and spousal abuse.

As a result of Base Realignment and Closure in Texas, Fort Bliss, Fort Hood and Fort Sam Houston will experience a large influx of troops and dependents over the next five years. For example, growth at Fort Bliss is estimated to be over 90,000 (see Dept. of Defense data below). Therefore, increasing mental health services capacity is a top priority.

	Baseline 2005		2006	2007	2008	2009	2010	2011	2012	Endstate 2012
		+/-	3844	948	2778	2764	7386	5901	4333	27954
Soldiers	9330	Cumulative	13174	14122	16900	19664	27050	32951	37284	37284
		+/-	2230	550	1611	1603	4284	3423	2513	16213
Spouses	4945	Cumulative	7175	7724	9336	10939	15223	18645	21158	21158
		+/-	2952	728	2134	2123	5672	4532	3328	21469
Children	10385	Cumulative	13337	14065	16199	18322	23994	28526	31854	31854
6-12 years		+/-	1004	248	725	722	1929	1541	1131	7299
(34%)	3531	Cumulative	4535	4782	5508	6229	8158	9699	10830	10830
13-18 years		+/-	856	211	619	616	1645	1314	965	6226
(29%)	3012	Cumulative	3868	4079	4698	5314	6959	8273	9238	9238
Total School		+/-	1860	459	1344	1337	3574	2855	2096	13525
Age	6543	Cumulative	8403	8862	10206	11543	15117	17972	20068	20068

Inevitably, given the inadequate state of the Veterans Affairs health care system, local community mental health and mental retardation centers will have to meet the needs of veterans, particularly in areas where the VA does not provide health services (e.g., many rural counties). Our state should lead the effort for nationwide DOD reform to ensure that an adequate mental health system is in place for returning soldiers and their families. Such advocacy should include:

- modification of discharge procedures to adequately record combat-related activity for soldiers whose service reflects exposure to TBI and/or PTSD conditions to favor the wounded warrior in the burden of proving such invisible wounds;

- development of best practices in the treatment of TBI and PTSD for active duty and discharged soldiers to return them to civilian life;
- establishment of support services for spouses and dependents of returning soldiers;
- working with individual states to establish a continuum of reporting and care, especially in rural and underserved areas; and
- promotion of federal legislation that establishes collaborative resilient warrior councils in regions with significant military populations so that federal, state and local resources are directed to best use.

The state needs to formulate a comprehensive state and community plan addressing the needs of these returning soldiers and their families, especially in relation to services for those suffering from PTSD and TBI.

Conclusion

Based on these facts, it is apparent that Texas faces numerous health-related challenges, many of which are exacerbated by poor access to health care, lack of resources, and a dismal health infrastructure. State leaders must address these problems to ensure a brighter, healthier future for Texas' citizens.

As such, our top priorities for the 81st session of the Texas Legislature include:

- expanding CHIP coverage,
- restoring 12-month continuous enrollment for Medicaid enrollees,
- increasing employer-sponsored health insurance,
- increasing the number of health care professionals in medically underserved areas throughout the state, and
- strengthening mental health services for returning soldiers and their families.

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